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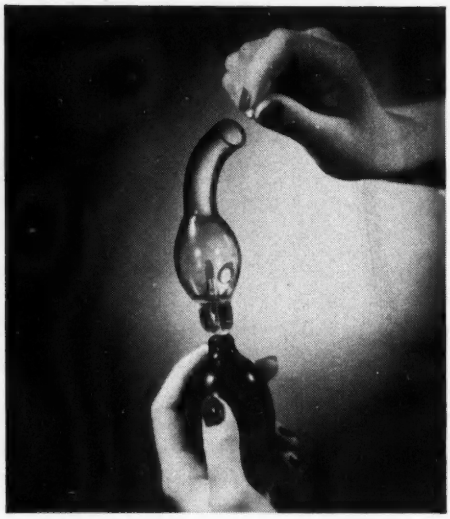

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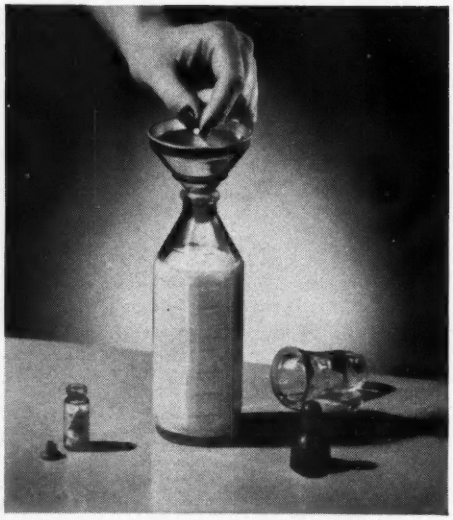

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California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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Western Equine and St. Louis Encephalomyelitis

The Distribution and Histological Nature of Central Nervous System Lesions

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SUMMARY

In a clinical review of 50 cases of western equine and 16 cases of St. Louis encephalomyelitis in humans it was noted that fever, headache, lethargy, drowsiness, tremor and stiffness of the neck were the most frequent signs or symptoms initiating the illness. The great majority of patients recovered without residual effect.

These two diseases of the central nervous system can only be differentiated on an immunological basis but may be suspected during seasonal periods in geographical areas where these virus infections are known to exist.

Neuropathological studies were done in four cases of human western equine and two cases of St. Louis encephalomyelitis. The primary point of attack by the virus is the cell body, the lesions being concentrated in the striate body, diencephalon, the brain stem and cerebellum. All histo-anatomical findings (nerve cell destruction, microglial nests, small isolated and confluent areas of necrosis and perivascular round cell infiltration) are secondary to the injury of the nerve cell body caused by the neurotropic virus.

BECAUSE of the epidemic potentialities of western equine and St. Louis types of the arthropod-borne viral encephalomyelitides occurring in humans and horses in the Central Valley of California, the State Department of Public Health established an Encephalitis Study Unit which has been carrying on its investigations for the past five years. Much of the original epidemiological investigation was pioneered by Meyer[5] and Howitt,[4] and in recent years has been extended by Hammon and his co-workers.[3]

The epidemiological data of the Study Unit upon which these neuropathologic findings are based indicate that the viruses of western equine and St. Louis types, while occurring predominantly in the Central Valley, are not restricted to it. Mosquito studies have demonstrated that C. tarsalis appears to be the primary vector for western equine encephalomyelitis. Correlation of immunologically proven cases of western equine (horse) encephalomyelitis, western equine human encephalomyelitis and human St. Louis encephalomyelitis with the presence of the viruses in mosquito pools in the months of June through September has been noted. The presence of the viruses in mosquito pools occurred most frequently during the early summer. Western equine encephalomyelitis in horses occurred more frequently in midsummer. Proven human western cases first appeared in early summer, while the first human St. Louis cases did not appear until later in summer. The human western equine cases were most frequent during the late summer, while the human St. Louis cases predominated in the early fall months.

Presented before the Section on Psychiatry and Neurology at the 79th Annual Session of the California Medical Association, April 30-May 3, 1950, San Diego.

The present study is a combined undertaking of the Encephalitis Study Unit of the California State Department of Public Health and the Division of Neuropsychiatry, Department of Medicine, and Laboratory of Neuropathology, Department of Pathology, of Stanford University Medical School.

Fifty proven human cases of western equine and 16 of St. Louis encephalomyelitis occurring in 1947 and established by the Virus and Rickettsial Disease Laboratory of the State Health Department are the basis for the following brief and epidemiologic clinical data. A proved case is defined as one in which, in paired specimens of blood, there is significant rise in antibody titer between acute and convalescent specimens, or in which there is isolation and identification of the virus from the brain.* Although a few of the patients at the time of the onset of illness were in the mountains surrounding the valley or in the coastal cities, all of them, without exception, had recently been in the Central Valley where the virus and its vector were known to exist. The age distribution was from six months to 60 years, the cases being fairly uniformly distributed through this age range for both types of virus infection. In children, the incidence was about equal in both sexes, but in adults it was higher in males.

Fever, headache, lethargy, drowsiness and stiffness of the neck were the five most frequent signs or symptoms at the onset or during the first three days of illness. Tremors, particularly of the hands, were present in one-third of the adult patients. Convulsions were more common in children. The great majority of the patients recovered and returned to their duties within a week to ten days after the onset of the illness. Five had neurologic residual effects when examined approximately one year later. Eight of the patients died, six from western equine and two from St. Louis encephalomyelitis.

Following is a description of characteristic onset of either human equine or St. Louis encephalomyelitis:

The adult patient first complains of headache. This is followed within a day or two by the complaint of fever and a tight or stiff sensation in the back of the neck. Within the first five days, either the patient himself will note drowsiness or some member of the family will call attention to it. Involuntary tremor of the hands is significant (although it occurred in only one-third of the cases in the present series). In children, headache, fever and listlessness are preceded by restlessness and irritability. The clinical onset is therefore clearly nonspecific but suggestive in recognized geographical areas in seasons when the infection is known to exist.

The spinal fluid contains an abnormally high number of cells, predominantly lymphocytes. (In the present series the total count was usually less than 100 cells per cu. mm.) The total protein content usually is normal or only slightly to moderately elevated, and the sugar and chloride contents normal.

Clinically, human western equine cannot be differentiated from St. Louis encephalomyelitis. The *onset* of the disease may be difficult to differentiate from the *onset* of poliomyelitis.

*The reader interested in further detail on method is referred to "Diagnostic Procedures for Virus and Rickettsial Diseases," First Edition, 1948, Publication Office, American Public Health Association, 1790 Broadway, N.Y.C.

The preceding description, a composite of experience in the 66 cases observed in the present study, is not greatly different from previous reports in the literature. There are excellent reviews of clinical findings, differential diagnostic considerations and various aspects of the epidemiology of these infections currently available in the literature.[1, 2, 3, 7] Further and more detailed elaboration and analysis of data collected by the Study Unit are to be published.

The following neuropathological observations were made in study of the brain and upper cervical spinal cord (more caudad levels of the cord were not available) in four cases of human western equine and two of St. Louis encephalomyelitis. In these cases the patients died in from three days to three weeks of the onset of illness.

In every instance, the primary point of attack was the neuron cell body, either by single organisms or by groups of them (Figure 1). The lesions were dis-

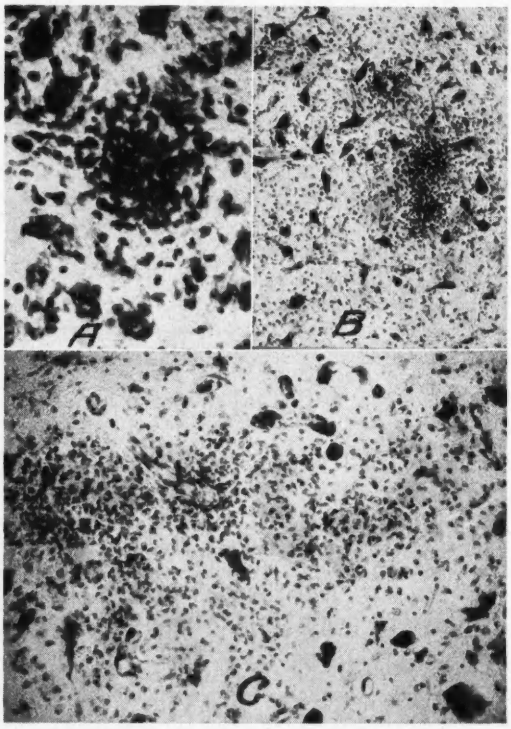

Figure 1.—*A*—A nest of reacting cellular elements, mostly reacting microglial cells to a single injured neuron of the dentate nucleus. A few polymorphonuclear leukocytes can be made out in this young "nest" of reacting cellular elements.

B—Above: A "nest" of predominantly reacting microglial elements to a single neuron, a part of which can be made out in the center of the "nest." *Below:* A confluence of two glial "nests" in reaction to two or more neurons in one of the nuclei of the thalamus.

C—A confluence of several glial "nests." The absence of several neurons is clearly illustrated. The reacting glial elements may likewise be seen to be breaking down and dispersing, a later stage than the "nests" observed in *'A'* and *'B'*. Region: Thalamus.

This and the following histologic microphotographs from Nissl-stained preparations.

tributed throughout the central nervous system, but were primarily in the thalamus, striate body nuclei, pontine nuclei and Purkinje cell and molecular cell layers of the cerebellar cortex (Figure 2). Ganglion cells were involved in sparsely scattered but different regions and layers of the cerebral cortex (Figure 3). Scattered ganglion cells were involved in the inferior olives, dentate nuclei, nuclei of the tegmentum of the brain stem and lateral and dorsal horns of the cervical spinal cord. The reacting cellular response to neuronal injury consisted of a proliferation primarily of microglia forming "nests" of

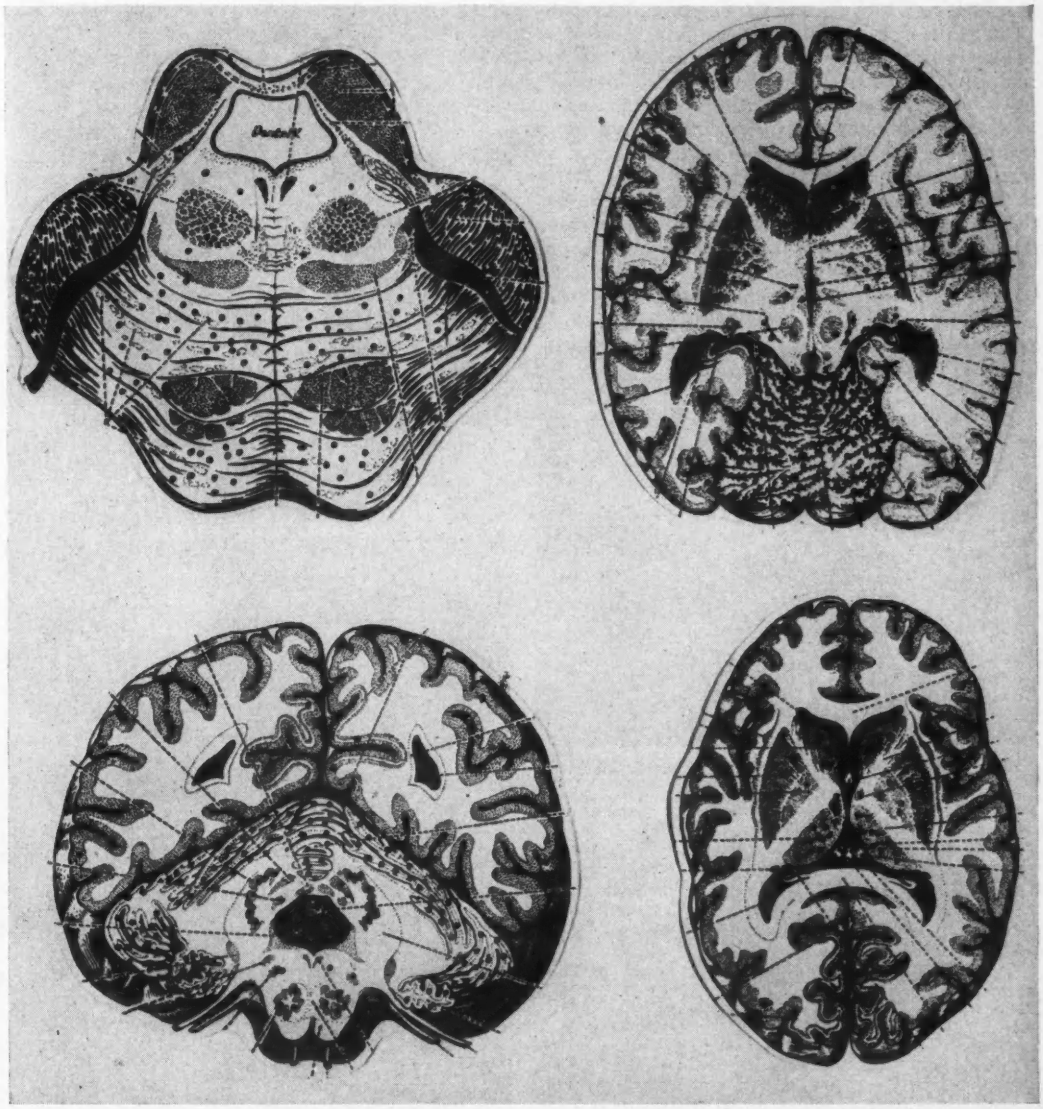

Figure 2.—A diagrammatic summary of the dots illustrating the distribution of lesions in the cerebral hemispheres, brain stem and cerebellum from this study of four cases of human western equine and two cases of human St. Louis encephalomyelitis.

Upper left: Section through the pons, showing distribution of lesions predominantly in the pontine nuclei with some few scattered lesions in the tegmentum.

Upper right: Horizontal section through the lower level of the basal nuclei and the cerebrum showing the lesions to lie predominantly in the caudate, putamen, globus pallidus and cerebellar cortex with more sparsely scattered lesions in the cerebral cortex.

Lower left: Frontal section through the occipital-parietal cerebral cortex, cerebellum and medulla oblongata showing a predominance of lesions in the cerebellar cortex, dentate and olivary nuclei with sparsely scattered lesions in the parietal occipital cerebral cortex and reticular region of the medulla oblongata.

Lower right: Horizontal section of the cerebral hemispheres through the upper level of the upper levels of the caudate, putamen and thalamus, illustrating a predominance of lesions in these structures with again sparsely scattered lesions in all parts of the cerebral cortex.

varying sizes and densities depending upon the number of ganglion cells involved and the age of the lesion (Figure 1). A scattering of neutrophilic leukocytes was commonly present in the younger-appearing microglial "nests." In the molecular layer of the cerebellar cortex large glial "nests" appeared about the elaborate branching dendrites of damaged Purkinje cells (Figure 4). The complete destruction of Purkinje cells in widespread regions of the cerebellum without reacting cellular response was dramatic in the material from two cases (Figure 5). Occasional microglial "nests" were found in the subcortical white matter of both cerebrum and cerebellum. A characteristic lesion was a sharply demarcated spongy amorphous lesion usually larger than the microglial "nests" (Figure 6, *C*). The fact that these amorphous spongy lesions were encountered where "nests" of microglia appeared to be undergoing necrosis from the periphery toward the center suggested that such lesions were the end result of this necrotic process (Figure 6, *A, B, C*). Infiltration of the perivascular spaces by mononuclear cells, mostly lymphocytes, near or in the vicinity of the lesions, was a common but variable finding (Figure 6, *C*). Such infiltration was less pronounced in those cases in which the patient died during the first few days of illness. A rare finding was a "ring" capillary hemorrhage. Only one such lesion was observed in each of two of the six cases. Changes within the blood vessel walls, endothelial proliferation, and vascular occlusion were not encountered.

The neuropathological findings described are in agreement with some but not all previous reports in the literature.[1, 2, 7] In general they resemble the neurohistopathological findings for eastern equine encephalomyelitis if one compares similar acute stages.[1, 7] However, in the authors' opinion the neuropathological literature has not stressed that the neuron cell body is the initial and primary parenchymal element injured by the specific arthropod-borne virus. All other histopathological findings are secondary to and symptomatic of the injured neuron cell body. The variability of the neurohistopathological findings from case to case is to be explained by (1) the fulminating character of virus infection, (2) defense mechanism of the body and (3) stage of infection (i.e., acute or chronic). These factors have far more influence in

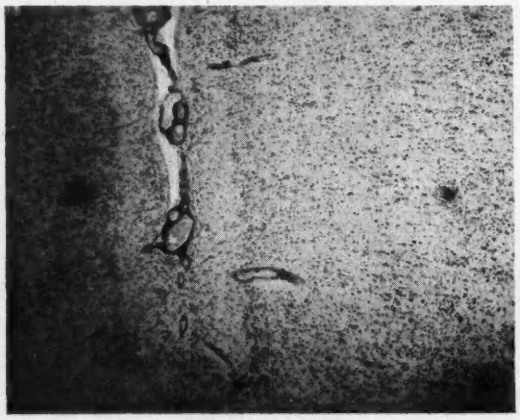

Figure 3.—Two "nests" of reacting cellular elements, mostly microglia, to one or more injured neurons of the cerebral cortex. On the left the "nest" lies in the second cortical layer and on the right in the fourth granular near the fifth pyramidal cortical layer.

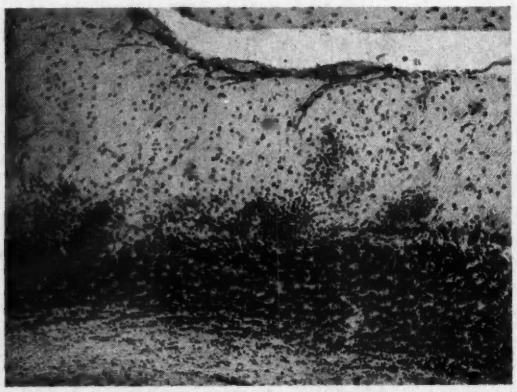

Figure 4.—Irregular groups and branches of reacting microglial elements in the region of destroyed Purkinje cells and extending into the molecular layer along the course of the branching dendrites of the injured Purkinje neuron bodies.

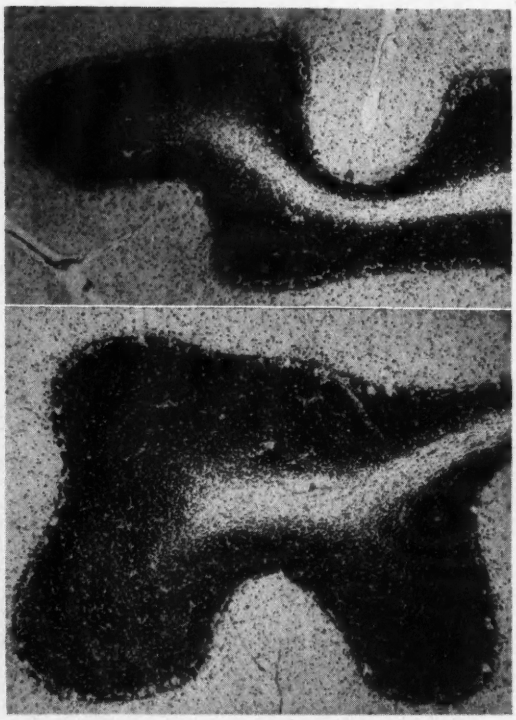

Figure 5.—*Above:* Normal Purkinje cell distribution in the normal human cerebellar cortex. *Below:* Absence of Purkinje cells with little or no reacting cellular elements from the cerebellar cortex of an acute and fatal case of human western equine encephalomyelitis.

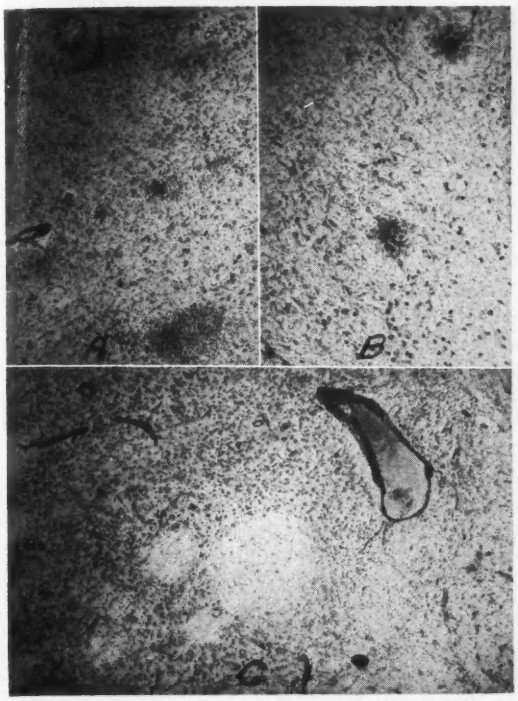

Figure 6.—*A*—Numerous ill-defined and dispersing remains of reacting microglial "nests."

B—Two, probably, still older microglial "nests" with an amorphous pale halo around their periphery.

C—Pale, sharply outlined, amorphous, spongy lesions, interpreted as a late stage of what was originally an active reacting glial "nest." It may be seen how a confluence of several of these individual amorphous lesions could produce a much larger region of necrosis. In the upper right hand corner of *C* lies a vein with a collar of lymphocytes in the periadventitial space.

determining the character and distribution of the pathologic changes within the central nervous system than has the type of arthropod virus (i.e., St. Louis, western or probably any of the other types, as eastern or Japanese B). The anatomical changes observed in the cases here reported upon were strikingly similar to those reported by Zimmerman[8] in Japanese B encephalomyelitis. Calcium deposition in the brain parenchyma and blood vessel walls, such as was noted by Zimmerman at postmortem examination of patients who died after comparatively long illness, was not observed in the six autopsies in the present series. Since none of the six patients lived beyond the third week of illness, the absence of calcium deposition supports Zimmerman's conclusion that calcium deposition is related to later degenerative and regressive changes. Noran and Baker[5] have excellently described gross and microscopic observations in a case of western equine encephalomyelitis in which the patient died three and a half years after the onset of the acute illness. They expressed the opinion that the parenchymal damage was due to anoxemia from primary vascular disease and occlusion. However, in the examinations in the present series the primary damage was observed to be to the ganglion cell, while the vascular changes were non-existent except for perivascular cuffing which is a subacute reaction to any parenchymal damage. The confluence of the necrotic amorphous spongy lesions in the later stage could explain the cystic and vascular changes observed by Noran and Baker. Calcium deposition in damaged parenchyma and related blood vessels, as reported by Noran and Baker and by Zimmerman, is a recognized late and chronic regressive chemical change in any part of the body, regardless of the primary disease.

The neuropathological characteristics which are most compatible with, although not necessarily limited to, western equine and St. Louis encephalomyelitis (and probably also the other arthropod neurotropic viral infections) are: (1) Primary injury to the cell body of the neuron by the virus, (2) the tendency for the distribution of the lesions to occur throughout the central nervous system but to be concentrated in the striate body, thalamic nuclei, pontine nuclei, Purkinje and molecular cell layers of the cerebellum, (3) the striking vulnerability of the Purkinje cells, and (4) the subacute, later-developing circumscribed amorphous spongy lesions from a necrotizing process of the earlier single and confluent glial "nests."

450 Sutter Street.

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The Problem of the Poor Reader

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SUMMARY

Children who are retarded readers may present a complex problem involving physical impediments, emotional distress, or teaching methods. A child with specific ***reading disability has spatial confusion, an exaggeration or persistence of a normal childhood tendency to reversal of letters and symbols, ambidexterity, normal intelligence, and poor visual recall of words. Children with these characteristics fail to learn to read in a teaching system in which the main emphasis is on visual associations. Treatment of such reading difficulties, as well as prophylactic measures, is outlined.***

POOR readers are a problem not only for the ophthalmologist, but also for the pediatrician, psychiatrist, otolaryngologist and educator, because the disability may concern the eyes, the ears, a personality disorder or a teaching method. The ophthalmologist is frequently consulted to investigate children who have great difficulty in learning to read during the first few years of school. When this is the chief presenting complaint, it is only occasionally that a specific ocular condition is found as the main cause of the lack of progress in reading. Many children are referred to the ophthalmologist by the teacher or parents for vague visual reasons, and only specific questioning establishes the true difficulty as a reading disability. "How does the child do in reading and spelling as compared with other subjects?" should be a specific question put to the parents by the ophthalmologist in order to establish whether or not the reading skill is disproportionately retarded.

"Reading disability" is the term usually applied if the child is disproportionately retarded in reading. This is often associated with poor writing and spelling while other skills such as arithmetic may be normal or better. This self-explanatory term is preferred to others such as alexia, word blindness, strephosymbolia, visual agnosia and others which have been used to describe one or another aspect of the broad problem. Such terms as left-handed reversals, or mirror reading and writing, describe only one type and serve to confuse by wrongly implying that all poor readers have reversal tendencies in reading or writing or have some degree of ambidexterity. For clinical purposes poor readers may be classified into two groups, those who have *specific* reading disability and those in whom the disability is *nonspecific:*

1. *Specific* reading disability is caused by a confusion in the recognition of language symbols. It is usually associated with ambidexterity, comparative clumsiness, and an exaggeration and persistence of the normal childhood tendency to reversal of letters and symbols. This specific reading disability frequently goes unrecognized, and children who have such a shortcoming are liable to more severe trauma than are children with other kinds of reading disabilities. However, they are only a part of a large group of poor readers who should be differentiated from those who have *nonspecific* reading disabilities.

2. *Nonspecific* reading disability: For children in this group the lack of progress in learning to read may be due to low intelligence, lack of interest, insufficient readiness to read, ocular abnormalities, hearing defects, emotional problems in the school or home, and other obstacles to learning.

Since reading is such an important tool in the learning process, inability to master it may lead to a complexity of secondary conditions such as stuttering and emotional behavior problems. The mixed picture that may develop within a few years makes it difficult to untangle cause and effect. The resulting emotional problems, speech defects and blocked learning processes may be by-products of an original specific reading disability, and these by-products may assume greater importance than the original handicap. On the other hand, these factors may be the cause of retarded reading ability. It frequently requires the teamwork of an ophthalmologist, pediatrician, child psychiatrist, child psychologist, otolaryngologist and educator to make proper evaluation in a given case.

It is therefore important to be able to recognize *specific* reading disability. If a child *is* found to have a specific reading disability, then more direct attention may be focused on the reading problem and alternative methods of teaching him may be used in order to supply him with the necessary tools to become a good reader. Even here, the by-product of emotional problems that may arise because of repeated failures of the normally intelligent child to learn reading may merit special attention. A more direct attack, however, on the reading disability may be made with expectation of success in the cases of specific reading disability. If, on the other hand, the child is found *not* to have a specific reading disability, then the investigating consultants must determine which of the factors previously mentioned require attention and the relative importance of each factor. In cases of nonspecific reading dis-

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ability the emphasis should be placed on an investigation of the emotional or physical obstacles; the problem is primarily in the domain of the child psychiatrist and pediatrician rather than in that of the remedial reading teacher. Concomitant treatment of both problems is often necessary, and usually the success achieved is not as striking as it is in treatment of specific disability.

What are the characteristics of a specific reading disability? It is more common among boys than girls. There is a high incidence of left-handedness or ambidexterity, with a confusion between right and left, with an exaggeration and persistence of the normal childhood tendency to reversal of letters and symbols. This so-called "spatial confusion" causes the child to confuse *p* and *q*, *d* and *b*, etc. Short words tend to be reversed (*was* for *saw*, *on* for *no*) or confused (as *dog* and *boy*, *stop* and *tops*). Many beginners normally have such tendencies but outgrow them once they establish correct left-to-right sequences. Children with spatial confusion are not able to straighten this out; although of normal or high intelligence they have a very poor visual recall of words and are considerably impeded in the ability to read. There may be any degree of this situation, the most pronounced being mirror reading and writing.

Causes. The most common cause of a specific reading disability is the unfortunate application of a method of teaching wherein almost the entire emphasis is on visual recall to children who happen to have a specific deficiency in that task. These children with exaggerated spatial confusion and poor visual recall are especial victims of the "flash" method of teaching reading evolved by psychologists. By this method, almost the entire emphasis is on visual association. With this method, whole words may be "flashed" for the child to learn, sometimes with pictorial associations. It was found that for most children phrases and even short sentences could be learned as quickly as words, so these are flashed, with emphasis on the visual memory. The alphabet is more or less ignored. The educational emphasis is on speed and "learning by looking." This system works well for the majority of children, but for a child with spatial confusion and poor visual recall, it is catastrophic. He simply cannot learn by this method alone in spite of intelligence, effort and persuasion. This block may well be the cornerstone in the development of subsequent personality and speech disorders.

The neurological basis of a specific reading disability is for the most part unknown. Orton expressed the belief that the two cerebral hemispheres receive mirror images and that one becomes dominant: If the right cerebral hemisphere is dominant, the individual becomes left-handed, and early confusion in a right-handed world leads to a mixed dominance and exaggerated reversals. Cases have been reported of acquired disabilities with lesions of the dominant angular gyrus. It is probable that these are merely cases of unusual association of perceptual and motor skills as a sex-linked characteristic in left-handed or ambidextrous children.

Diagnosis. A presumptive clinical diagnosis of a specific reading disability may be made by noting a disproportionate inability to read, write or spell in otherwise intelligent children who are left-handed or ambidextrous and who confuse or reverse short words such as *was* and *saw*, *on* and *no*, *now* and *how*, *who* and *how*, *very* and *every*, and *ate* and *eat*, when asked to write or read such a list. Further tests may then be made to establish the exact nature of the specific reading disability. Most reading aptitude tests now in existence establish only that the child is a retarded reader, but do not truly differentiate the factors of spatial confusion, comprehension, vocabulary problems, "word reading," etc. Tests to help in making the distinctions are now being devised by the Reading Clinic at the Stanford University School of Medicine.

Treatment. Treatment should logically be directed at furnishing these children with alternative methods of learning to read. This may be done by reinforcing the visual method with phonetic, kinesthetic and auditory cues. In other words, the child needs to hear the word as well as see it, to break it up into parts and say it, and to feel it by writing it. Reliance should not be placed on just one of these cues, such as Orton's phonetics or Fernald's kinesthetics. A more eclectic approach to discover any suitable combination of methods in a given case should be used. The therapist may start at some level of phonetics, adapt it to the child so that he may break up the word into sounds. The child then says the word as he traces it, then writes it from memory and uses it in a composition. Soon the word may be pronounced properly by sight with mental tracing and phonetics. If the child can now mentally "say it," he can write it and then use it. Soon he, too, can learn words by sight, utilizing his own methods and reinforcing the visual cues. Comprehension and exactness are emphasized, with speed being added later. The child will thus develop strong associations for seeing, reading, writing, spelling and speaking.

Children who have been retarded readers for some time in the present teaching system in schools present complex problems and should be examined by an investigative team. In some cases it is unwise to treat a reading disability alone without proper knowledge of the other obstacles. A therapist must not permit discovery of a poor reading situation (even though it is caused by a specific disability) to obscure a more important family emotional problem. If the child manifests some easily determined characteristics of the specific disability, then more direct attention may be focused on the reading problem, although proper evaluation of the emotional problems must be made. In some cases, sole attention may be directed at the reading disability. In others, concomitant treatment of the reading disability and the emotional problems should be insti-

tuted. In some cases, the by-product of the psychiatric problems may assume primary importance. It should be emphasized that this discussion concerns principally the specific reading disability, and that in cases of the nonspecific disability outlined previously, the treatment is usually not directed solely at the reading problem.

Early recognition of difficulty in learning to read under the present system of teaching is important. Children who persist in exaggerated confusion by reading *boy* for *dog* or *God*, or who pronounce any of those words thoroughly garbled as *odg*, should be grouped together for an alternative method of teaching, incorporating phonetic and kinesthetic as well as visual cues. Furnishing the child with some tool by which he may learn to read at this stage may obviate many of the difficulties that may arise if the disability is overlooked. Children still unable to learn by supplementing phonetics and kinesthetics should be examined by people capable of evaluating intelligence quotient, visual and hearing handicaps, and emotional problems.

Prophylaxis. Prophylactic measures may be carried out in the field of reading problems in purest and simplest form by combining phonetic, kinesthetic and visual methods in the teaching of reading skills. Some children learn to read with very little instruction. "If a single method of learning is forced upon a group of individuals, the result will be that some of them will fail." If in the teaching of reading skills the child is offered several tools by which he may learn, he will select those best suited to his own capabilities. A teacher might combine the learning of the alphabet with the sounds of the letters and simple syllables, then add letter combinations in conjunction with words that are spoken, written and used. The child who has a specific reading disability will then be able to utilize his own system in learning these skills, although perhaps more slowly. Children who learn best by visual cues alone will also have alternative tools with which to master longer, unknown words. With the older, and unfortunately somewhat outmoded, methods of learning to read, the strong association between phonetics and kinesthetics made for an initial impediment in facility for silent reading or rapid comprehension. But this impediment is by no means insurmountable, as most persons so taught have found. A person with a specific reading disability learns to read better with the older combined methods of teaching.

For the present, there is no question that the majority of children learn faster and more easily by the visual flash method. But since there is a significantly higher incidence of the specific reading disability casualty by this method alone, other methods must be incorporated. Certainly the teacher should not, as is done in certain school systems, intensify the flash system when a child learns poorly by it. This is an example of "redoubling the effort when we have forgotten the aim." The aim is to teach children to read, not to confirm a particular system—to make it easier for all children to learn to read and to remove all possible obstacles as long as it is practical to do so. Many large cities have well organized remedial reading centers. Not many can boast of a logical educational program for the teaching of reading skills to avoid the pitfalls that make remedial reading centers necessary.

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Hemorrhage of Late Pregnancy

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John T. Cole, M.D., *New York*

SUMMARY

Rupture of the uterus, cesarean section and uterine atony were the major causes of maternal death associated with hemorrhage of late pregnancy for the five years 1945 to 1949 in New York County. Shock occurred earliest in rupture of the uterus and cesarean section, while in uterine atony there was some delay before shock was evident. Placenta previa was preceded by an initial small hemorrhage, and the time interval before shock was relatively long. It appeared that in cases of retained placenta, manual removal of the organ and hysterectomy were unduly delayed. Ten per cent of the maternal deaths reviewed were associated with severe transfusion reactions. Early recognition of a serious situation, rapid blood replacement and hysterectomy might have salvaged most of the patients.

A MATERNAL death rate of considerably less than one per thousand was anticipated in the United States for the year 1950.[2] Many improvements and advances in the care of pregnant women have contributed to the reduced mortality rate. This represents the first time in medical history that a large country has been able to surpass the theoretical minimum. Not only should this low rate be maintained but such results should stimulate increased effort in this direction.

A study of the maternal mortality for New York City with its heterogeneous population shows that the major causes of death remain infection, toxemia and hemorrhage. In contrast to the pronounced decrease in deaths (Chart 1) due to puerperal infection, there has been relatively little change in the number of deaths due to toxemia and hemorrhage. Indeed, it appears that hemorrhage[3] outranks all other single causes of maternal deaths in the United States today. The work of several maternal welfare committees indicates that probably more than 75 per cent of hemorrhagic deaths are preventable. Therefore, in order to further reduce maternal mortality, the prevention, control and treatment of hemorrhage must be improved.

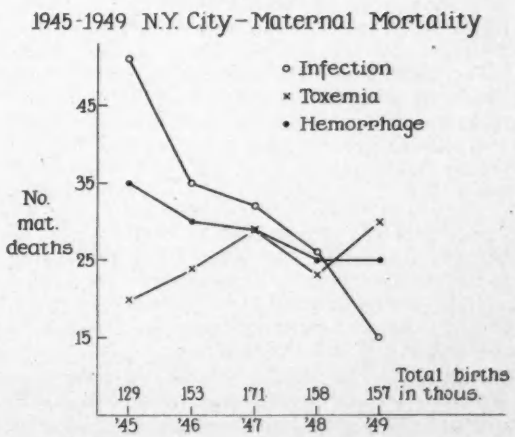
It occurred to the authors that a detailed study of maternal deaths resulting from hemorrhage might provide valuable and useful information pertaining to etiologic factors and problems in management. Obviously, the data subjected to analysis should be of recent origin when all of the present therapeutic armamentaria were available. No single institution has accumulated a sufficiently large clinical experience of this kind during the past five years. Accordingly, reports of 50 cases in which maternal death was associated with late obstetric hemorrhage were taken from the files of the New York County (Borough of Manhattan) Maternal Welfare Committee. The deaths occurred in the five-year period 1945-49. The Maternal Welfare Committee collected detailed information from the physicians and hospitals concerned. It is the purpose of this report to analyze the chief cause of hemorrhage, the time of shock, the amount and speed of blood replacement, and any other treatment. In addition a summary will be given of the plan to combat hemorrhage in operation at The New York Lying-In Hospital. The results obtained during the same period will be cited. Recommendations will be advanced in the light of this experience with the hope that other unfortunate circumstances may be avoided in the future.

The causes of maternal death from late hemorrhage in the cases reviewed are shown in Table 1.

UTERINE RUPTURE

In the 13 cases in which maternal death was associated with rupture of the uterus, nine of the infants were deadborn and four were living. There were six instances of disproportion of some degree which included hydrocephalus, difficulty with the aftercoming head and attempted version after attempt to deliver with forceps had failed. Two maternal deaths resulted from rupture at the site of previous uterine

CHART 1



From the Department of Obstetrics and Gynecology of the Cornell University Medical College and the New York Lying-In Hospital.

Guest speaker's address read before the second general meeting of the 79th Annual Session of the California Medical Association, April 30-May 3, 1950, San Diego.

TABLE 1.—*Causes of 50 Deaths from Hemorrhage, New York County, 1945-1949*

Rupture of uterus	13
Atony of uterus	12
Following cesarean section	8
Placenta previa	5
Trauma and retained placenta	6
Premature separation of placenta	4
Other	2
Total	50

scars. In two other instances the uterus apparently was ruptured during the process of manually removing the placenta. In one case, rupture occurred during induction of labor following the administration of Pitocin® intramuscularly. Rupture of the lateral wall of the uterus followed during the rapid labor and the birth of an 8-pound stillborn infant. The uterus was ruptured in another patient with placenta previa while internal podalic version was being carried out. In one case there was spontaneous rupture at term associated with the delivery of a well infant. Some brief comment with respect to the management of these patients with rupture of the uterus follows:

In three cases, the initial shock and hemorrhage were overcome, but secondary complicating factors (blood incompatibility, massive pulmonary atelectasis and peritonitis) resulted in death. Shock occurred extremely early and was often the first important clinical finding in conjunction with vaginal bleeding and abdominal pain. In eight cases, an hour or less elapsed before shock occurred. In one-half of the patients blood was not available until shock supervened. The blood loss was difficult to estimate but was thought to vary between 500 cc. and 3,000 cc. It is probable that in most instances the actual loss was considerably in excess of these figures. Blood replacement was carried out in nine cases: 2,000 cc. was given in two instances, 1,500 cc. in three, and 500 cc. in four. In two cases the uterus was packed without recognition that rupture had occurred, and in three cases hysterectomy was done as a last desperate measure with the patient in profound shock. It is apparent from these data that in most instances complicating factors which should have dictated preparations for transfusion were present. It is particularly striking that of the 15 patients with hemorrhage and shock, four were given only 500 cc. of blood and four were given no real supportive treatment.

UTERINE ATONY

In the 12 cases of postpartum uterine atony, all infants but one were born alive. The highest parity in this group was four. The pregnancies and deliveries were uncomplicated and there was nothing unusual in previous obstetrical histories. (In striking contrast, in the other cases detailed in Table 1 the complications were recognized and an opportunity provided for consultation and expert care.) In the cases of uterine atony the average blood loss was estimated to be 2,500 cc. and the replacement was only 750 cc. In one instance, blood was administered 15 minutes after the onset of hemorrhage. However, the total amount given was only 1,000 cc. (total loss 3,000 cc.) and the patient died in three hours. On the average, however, blood replacement was not started until 1½ hours after the onset of hemorrhage. The largest amount of blood received was 4,000 cc. Two patients received no blood. In five instances, the uterus was packed with gauze—in four cases within 20 minutes and in one after three hours. At no time did the packing even temporarily appear to control the bleeding. In two cases, hysterectomy was performed late with the patients in poor condition. Hysterectomy was contemplated in the remainder but was not carried out because of inadequate blood supplies and deep shock. The average time factors in postpartum uterine atony indicated that shock occurred within two hours and death about one hour later (Chart 3).

CESAREAN SECTION

Eight maternal deaths were directly associated with cesarean section. In this group, seven infants were well and one died of hydrocephalus. In four cases the operation was an uncomplicated elective repeat procedure, while in three instances it was associated with labor and disproportion. In one case the operation was done because of history of adherent placenta in a previous pregnancy. A severe puerperal infection developed in one case and on the 32nd postpartum day hemorrhage occurred. (In all calculations of average time, this case was excluded.) The average blood loss in the cases in which death occurred following cesarean section was estimated at 3,000 cc. It is of interest that in five cases, only one unit of blood was available, and on one occasion no blood could be obtained. In this group of six patients for whom there was not adequate blood for transfusion shock occurred in one hour and death in two hours. The remaining two patients received larger quantities of blood and death occurred after a longer interval. On two occasions hysterectomy was carried out immediately following cesarean section because of uncontrolled hemorrhage.

PLACENTA PREVIA

Four maternal deaths were associated with placenta previa. Three living infants were delivered by low flap section and one was delivered deadborn through the normal birth passages. In all cases, two episodes of bleeding could be distinguished. The first was mild and the second fatal. Adequate blood was available in only one instance, and then transfusion was not started until two hours after the onset of hemorrhage. In one case hysterectomy was carried out after shock had occurred. In two cases the uterus was packed in the course of cesarean section without effective hemostasis. The average interval before shock was four and one-half hours—adequate time for securing necessary blood supplies in most circumstances.

TRAUMA

Multiple attempts at high forceps delivery and failure to recognize traumatic injury and associated blood loss resulted in three maternal deaths. All infants were deadborn. Blood was not administered and no attempt at repair was made until after the development of deep shock. The absence of adequate supportive measures, especially blood transfusions, is particularly striking in this group.

RETAINED PLACENTA

In three instances the placenta could not be expressed following uncomplicated delivery, and several attempts (manual) were necessary before the complete removal of the placenta was accomplished. Blood was not made available for transfusion. In one instance, the uterus was packed while the placenta was in place. In another, inversion of the uterus was not adequately treated. Despite bleeding, shock and an average duration of five hours for the third stage of labor, hysterectomy was not done nor was blood given in any case.

PREMATURE SEPARATION

In two of the four cases in which death was associated with premature separation of the placenta, delivery was by the vaginal route. One patient died three days and the other nine days following transfusion reaction. In the other two instances, concealed hemorrhage occurred. Not until an hour after the onset of hemorrhage was blood available for transfusion, and then only one unit in each case. Cesarean section was done in both cases; shock occurred during the operation and in each case the patient died shortly after the completion of the procedure. Two of the four patients were found to have a classical Convelaire type of uterus. The average blood loss was estimated at 2,000 cc. The two patients who died after operation received one unit of blood each, while the two with transfusion reactions were given four units each. In the only case in which hysterectomy was done the bleeding was controlled but the patient died on the third day as a result of severe transfusion reaction.

Chart 2 shows data pertaining to the time and amount of blood administered correlated with the

CHART 2

1945-1949 N.Y. County - Blood Replaced

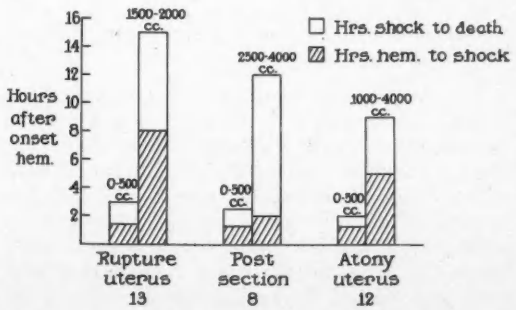
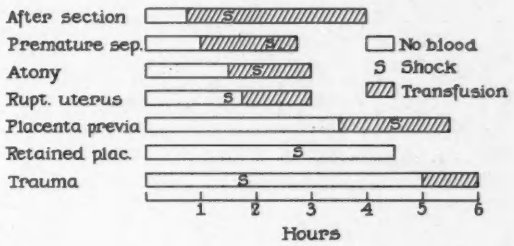


CHART 3

1945-1949 N.Y. County - Hemorrhagic Deaths



clinical course of the three major causes of hemorrhagic death. If no blood or only a single unit was available, shock intervened within one or two hours and death followed one hour later. If 1,000 to 4,000 cc. of blood was administered, shock occurred in from two to eight hours and death followed from five to ten hours later. In the cases in which such large volumes of blood were given, severe shock usually had been present too long and was irreversible; the blood served only to prolong life for a short time.

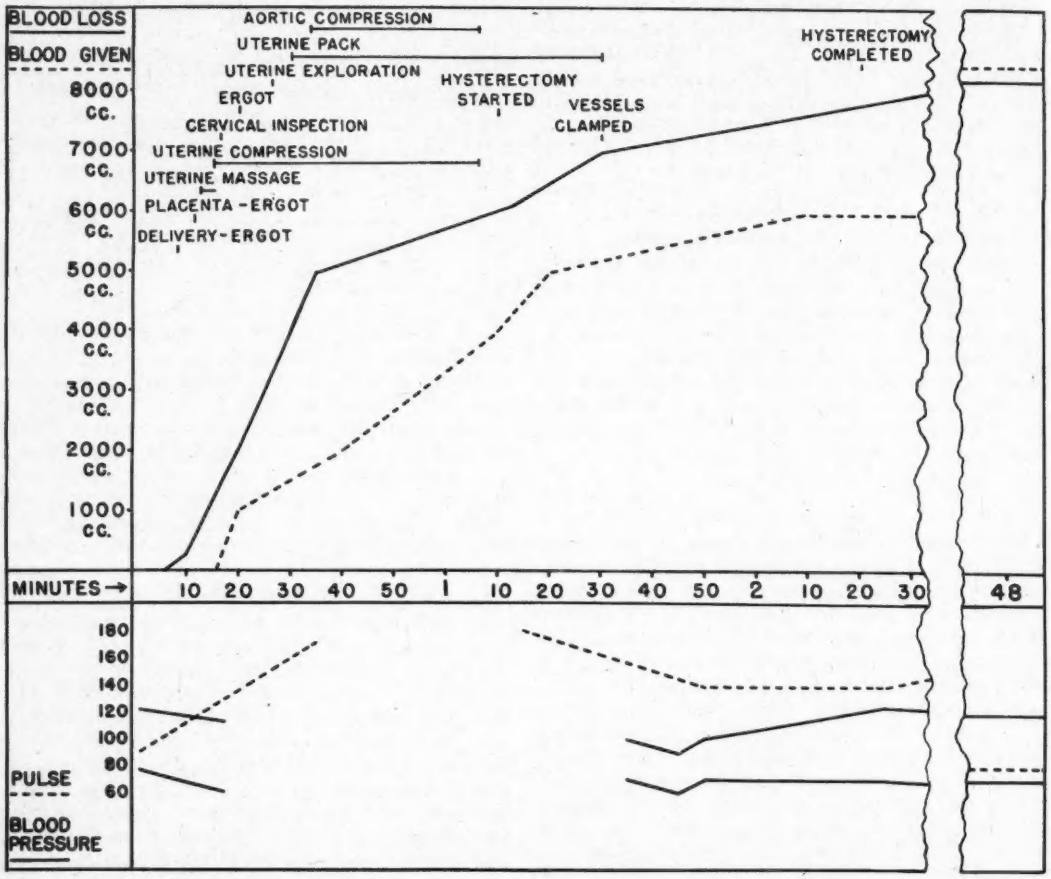
DISCUSSION

Chart 3 indicates the average time relationships between the onset of hemorrhage, shock, initial transfusion and death for each group previously discussed. In the cesarean section group one unit of blood was provided in every case, apparently because most operations are performed with at least one unit of blood available in the operating room. In those cases, moreover, in order that no time might be lost if blood should be needed, a needle for infusion was already in place in a vein in an extremity. The difficulty arose when no further blood could be obtained and shock occurred before additional supplies were available. Reliance upon a single unit of blood to combat hemorrhage complicating cesarean section was largely responsible for the deaths. The importance of careful observation for the first hour following operation is clearly demonstrated.

Shock occurred early in rupture of the uterus and in several instances it was the most significant initial clinical finding. The large loss of blood was often partially concealed in the broad ligament or in the peritoneal cavity. Prompt diagnosis and operation within the first hour after rupture with adequate blood transfusion and other supportive measures might well have averted disaster in all instances. With one exception, the patients had complications and difficulty in delivery which could have been predicted. In uterine atony, on the other hand, the hemorrhage could not be anticipated and bleeding did not start until the third stage of labor. Pregnancy and labor were usually normal.

The first abnormality in uterine atony consists of excessive loss of blood, and the cause usually can be determined by examining the fundus of the uterus. In these circumstances, it is essential for the well-being of the patient that procedures aimed

CHART 4



to control the hemorrhage and to replace the blood lost be performed rapidly. These measures should be carried out simultaneously (rather than in sequence as happened in so many of the cases here reviewed). Following is a report of severe unanticipated uterine atony to illustrate the appropriate and extreme measures often required.

CASE REPORT

The patient was a 36-year-old, para 2, gravida 2. The antepartum course was complicated by mild hypertensive disease. Two days after the expected date of confinement, the membranes ruptured spontaneously and labor ensued. Four and one-half hours later, at 2:25 a.m., the patient was delivered spontaneously of a full term, living child under local anesthesia. Two minutes later, the placenta was expressed spontaneously and intact. Profuse hemorrhage began immediately. The usual oxytocics and massage were of no avail. From two antecubital sites rapid, massive transfusion therapy was started within five minutes after the onset of hemorrhage. The cervix and uterus were both intact. A uterine pack did not lessen the bleeding. Combined uterine and aortic compression greatly reduced the rate of blood loss. It was felt that the problem was one of uncontrollable uterine atony and preparations were begun for hysterectomy. The patient's course and the therapy during the first critical hours are shown in Chart 4. It will be noted that the patient received almost nine units (550 cc. each) of citrated blood in the first hour following the initial hemorrhage. It was estimated that the total amount of blood lost was 8,200 cc., and during treatment 9,350 cc. of citrated whole blood was administered. The packed red cell volume dropped from a predelivery level of 38 per cent of the whole blood to a low of 28 per cent in the postpartum period. In addition there was a moderate depression of the calcium content of the blood. The patient had low grade, unexplained fever for one week. She was discharged as well on the 14th postpartum day.

The delayed onset of shock in placenta previa is striking as compared to the time interval in premature separation of the placenta (Chart 3). In placenta previa there was usually an initial short forewarning episode of bleeding which permitted time to make transfusion arrangements. In premature separation, shock was more rapid in onset, as in rupture of the uterus. The deaths from retained placenta and trauma during vaginal delivery all re-

sulted from errors in judgment and treatment in addition to the late and limited use of blood. When large quantities of blood are poured into the circulation, transfusion reactions are somewhat more likely to occur. Very often in these circumstances, the use of multiple types of blood becomes necessary, which further increases the chance of reaction. The importance of careful and rapid blood compatibility tests is illustrated by the fact that 10 per cent of the deaths were associated with the secondary complication of bilateral hemoglobin nephrosis. Adherence to accepted standard procedures would probably have eliminated these unfortunate results.

The analysis of these hemorrhagic disasters points out clearly some definite implications. In retrospect, the large majority of deaths appeared to be preventable. Failure to save the patient's life could be traced usually to poor appreciation of the seriousness of the situation, optimistic estimates of blood loss, reluctance or inability to begin transfusion therapy immediately, inadequate blood replacement, and late surgical intervention.

The efforts of the staff of The New York Lying-In Hospital to overcome the problem of hemorrhage have been described elsewhere in detail.[1] The preparations prior to and at the time of hemorrhage which have been used with very satisfactory results are as follows:

1. The blood group and the Rh factor are determined at the time of the first antepartum visit.

2. Blood is available in the operating or delivery room for midforceps delivery, cesarean section, manual removal of the placenta or other major obstetrical operation.

3. Hemorrhage may occur more frequently in other circumstances such as multiple pregnancy, excessive sized infants, vulval varicosities, myoma uteri, and deep anesthesia. Appropriate measures may be adopted according to the complication.

4. Although a large general blood bank may be available, an additional obstetric blood bank on the delivery floor, containing type O Rh negative blood treated with Witebsky[4] substance, is of inestimable value and makes possible the initiation of blood restoration in a matter of minutes.

5. Blood may be given rapidly under pressure (120 mm. of mercury) with large bore needles (No. 15).

6. A critical time factor after the onset of hemorrhage is important in massive obstetric hemorrhage. Studies indicate that rapid transfusion therapy must be commenced within minutes after massive hemorrhage if the patient's life is to be saved.

This outlines the policy which with minor variations, has been carried out since 1944. In 28,000 deliveries at the New York Lying-In Hospital from 1944 through 1949, only one private obstetrical patient died of hemorrhage, and there were no deaths from hemorrhage in 16,000 gynecologic operations.

530 East 70th Street.

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A New Position for Cholecystography (Kirklin)

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ROENTGENOLOGISTS are well aware that slight changes in the roentgenographic position may result in improved cholecystograms. In the usual position, the gallbladder may be obscured by (1) the spinal column because of the close proximity of the gallbladder to the spinal column, especially in slender persons, and (2) gas in loops of the intestine overlying the gallbladder. Not only are these problems solved but additional information is obtainable by placing the patient in the right lateral decubitus position and taking posterior-anterior views of the gallbladder as advocated by Kirklin.[1]

In addition to the usual equipment for cholecystography, a plain high table is used on which the patient lies in a true right lateral position with the abdomen against the x-ray table. The patient is immobilized in this position with a canvas band (Figure 1). The advantages of this position are:

1. The gallbladder tends to gravitate to the patient's right side, away from the spinal column (Figure 2) and the gas-filled intestines tend to rise above the heavy, filled gallbladder (Figure 3).

2. Movement of the patient which might blur the gallbladder shadow is easily avoided.

3. The contrast medium tends to enter the bile ducts in a greater number of cases (Figure 4).

4. More effective demonstration of the layering of the bile is achieved, a point of academic interest to many examiners.

From the Department of Radiology of the Rees-Stealy Clinic.

Presented before the Section on Radiology at the 79th Annual Session of the California Medical Association, April 30-May 3, 1950.

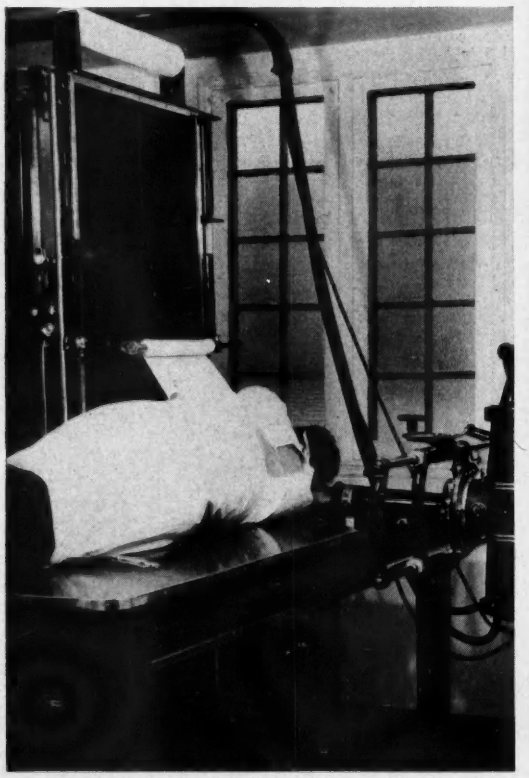

Figure 1.—Patient in right lateral decubitus position, immobilized with canvas band.

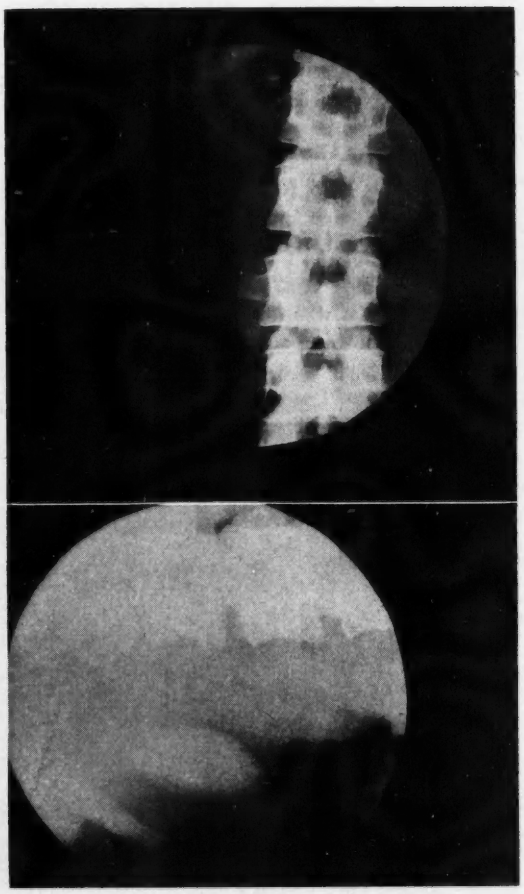

Figure 2.—*Upper:* Gallbladder obscured by spinal column in usual position. *Lower:* Gallbladder falling away from spinal column in decubitus position.

5. Gallstones which may not be visible on films taken in the usual position are demonstrated (Figures 5 and 6).

So efficient has this position proved to be in the author's experience that it is used routinely to supplement the usual cholecystographic procedure used in all cases.

2001 Fourth Avenue.

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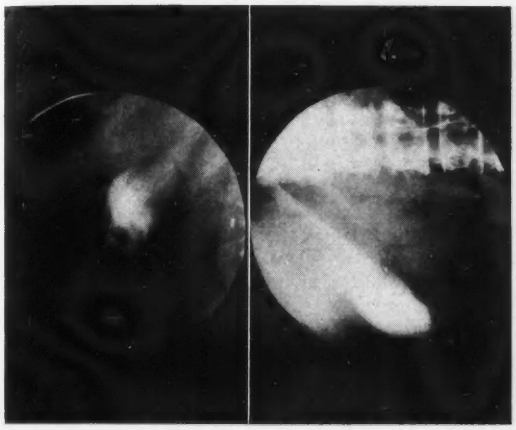

Figure 3.—*Left:* Gallbladder obscured by gas-filled intestines, in usual position. *Right:* Gas-filled intestines rising above gallbladder in decubitus position.

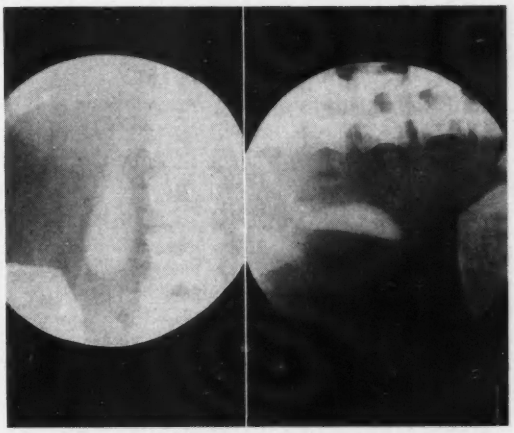

Figure 4.—*Left:* Bile ducts not demonstrated with patient in usual position. *Right:* Ducts filled with opaque medium with patient in decubitus position.

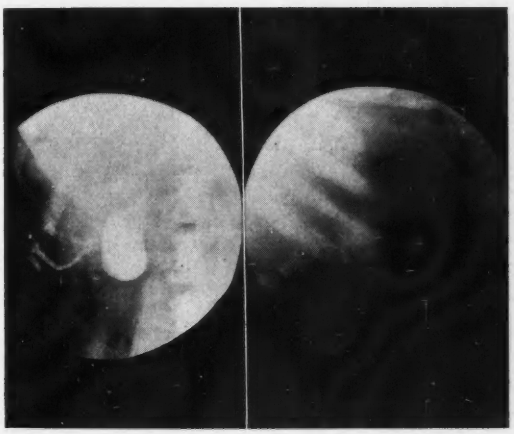

Figure 5.—*Left:* Gallstones not visible with patient in usual position. *Right:* Gallstones demonstrated with patient in decubitus position.

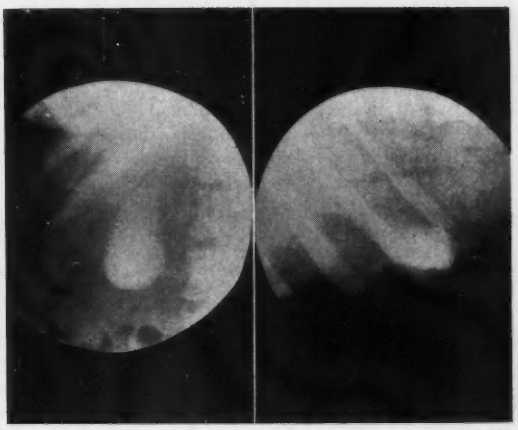

Figure 6.—*Left:* Gallstones not visible with patient in usual position. *Right:* Gallstones demonstrated with patient in decubitus position.

A Psychosomatic Approach to the Climacteric

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SUMMARY

Two major aspects of the climacteric in women are endocrinological changes with their effects upon the sympathetic nervous system, and psychological factors leading to anxiety with its effect upon the sympathetic nervous system. Depending upon the circumstances in each case, the interruption of the vicious cycle thereby established may require hormonal therapy, psychotherapy, or both. The mere correction of hormonal imbalance may fall far short of effective treatment.

ALL too often the physician is inclined to explain the symptoms of female patients in relation to menstrual function. In this connection, Young[9] commented: "Too frequently, nervousness in women between the ages of thirty and forty is glibly reduced to 'premature menopause'; where the age range is forty to fifty-five 'menopause' offers a handy explanation, and nervousness after fifty-five may be attributed to 'getting over the menopause.'" The two-thousand-year-old concept of untoward symptoms caused by the wanderings of the uterus has been replaced by the "scientific concept" that estrogen deficiency is the total explanation despite the observation by every physician treating patients in this epoch of life that there are many who do not benefit from estrogen substitution therapy.

HORMONAL INFLUENCE

Reporting upon endocrinological studies, Fluhmann and Murphy said: "Failing or absent ovarian function is not associated with a complete disappearance of substances having estrogenic properties. The hormone may be detected at cyclic intervals or it may be constant, but no relationship between climacteric symptoms and its absence could be established. The presence of excessive amounts of a gonadotropic substance, probably of anterior pituitary origin, bears a distinct relationship to the severity of the climacteric symptoms."

PSYCHOSOMATIC ASPECTS

In the past decade, internist, gynecologist, endocrinologist, and psychiatrist have come to agreement on the psychosomatic approach to the disordered climacterium.[1-9] It would be well to recall that in the life of the female the climacterium is a natural evolutionary period having a regressive quality the opposite of another evolutionary phase, puberty. Deutsch[2] stated: "Whatever influence the changes in hormonal activity may exert upon the whole psychosomatic picture, there is no doubt that the mastering of the psychologic reactions to the organic decline is one of the most difficult tasks of woman's life. The whole course of the climacterium is undoubtedly determined by the fact that with cessation of ovarian activity the remainder of the endocrine system is deranged in its functioning. The individual manifestations depend greatly on the given woman's personality." And Weiss,[8] in the same vein: "One may say that the glandular functions seem to furnish an impetus to the psychologic processes, but there must be a well integrated psychologic structure which can do something intelligent for the emotional needs of the individual who possesses the glands."

SYMPTOMATOLOGY

Contradictory statements appear in the literature regarding the incidence of symptoms. Weiss[8]: "It is estimated that at or about the time of the cessation of menstruation, 80 per cent of women experience a variety of unpleasant symptoms." Barnacle[1]: "It is generally agreed that about 80 per cent to 85 per cent of women have no complaints." Novak's[5, 6] point of view seems the most pragmatic: "Two facts are clearly established, one, that in only a small minority of women are the characteristic menopausal symptoms sufficiently severe to interfere materially with health and happiness as measured roughly by the necessity for medical attention, and, two, many of the symptoms complained of by women in the fifth decade of life are wrongly attributed to the menopause."

Those symptoms upon which there is the most universal agreement are the vasomotor which express the over-responsivity of the sympathetic nervous system in the characteristic hot flashes as well as in various other perturbations at the physiological level.

On the emotional side, anxiety is the central feature producing tension which, via the hypothalamus, reaches the oversensitive sympathetic system with disturbing nerve impulse bombardments. As a result there appear the various psychosomatic symptoms familiar to the clinician: hot flashes, cold shivers, emotional instability, insomnia, depression of spirits, tingling in the skin and extremities, headaches, giddiness, nausea, fatigue, dyspnea, sweating, and so on.

EMOTIONAL DYNAMICS[1, 2, 4]

Anxiety in the climacterium stems from a multitude of causes, the most important being the patient's own concept of herself. The woman in this phase of life is assailed by many threats to her

sense of self-esteem and self-worth. A decline in the beauty-creating activity of the gonadal secretions with the gradual loss of femininity as expressed in secondary sexual characteristics, attacks the woman's narcissistic adjustment. With the cessation of menses, the woman inevitably faces the loss of reproductive capacity. In the naive woman, this blow may be accompanied by the misconception that sexual activity is also at an end or may become uncontrollable. Then, too, the threat of senescence is increased by the cessation of the menses and the threat brings with it heightened insecurity, for now to biological decline are added fears of physical and social uselessness and even the spectre of social dependence. As though this were not enough, there is the situation in which the children, up to now more or less dependent upon the mother, are ready to leave the home, marry, and establish their independence of the mother, whose opportunities for service to them are decreased, adding to the feelings of lowered self-esteem. Finally, the contemporaries of the climacteric woman are similarly affected, are becoming restricted in their physical activities, are afflicted by illness, and some die. Outside the contracting social circle, new friends are harder to make, thus decreasing the rewards of friendship and turning the woman's attention and interest further within herself.

In a word, the clinical picture is one of mounting anxiety with its attendant strain upon a sympathetic nervous system in a state of heightened reactivity organically determined and enhanced. Therapy should be directed against this truly vicious cycle.

DIAGNOSIS[4]

If rational, successful therapy is to be carried out, the etiologic factors and their relative importance must be appraised.

The extent of the influence of hormonal deficiency in a given case may be determined in either or both of two ways—by endocrinological assays and/or the observation of response to a potent estrogen preparation and a placebo administered in alternating periods. The interpretations of these tests are not as obvious as they would seem, in that the mere presence of a pronounced endocrine deficit does not exclude the influence of psychogenic factors.

Recalling the influence of anxiety as a primary etiologic factor, the physician will determine its roots by sympathetic, patient listening to what the patient says of herself. That no hint of subjectivity, censure, prudery, or Jovian detachment be conveyed to the patient is of utmost importance. In the interview the physician should ascertain how much anxiety the patient has and what are its sources.

For example,[5, 6] it is patently clear that the 47-year-old woman who apprehensively reports to a physician that she has scanty menses, frequent hot flashes and sweats which disturb her rest at night, that she awakens with a panicky feeling, that she feels irritable, unstable, and cranky, noting headaches, vertigo, and depression, as well as other symptoms—it is quite clear that she does not require a prescription for natural or synthetic estrogen so much as she does an attempt to understand the psychological aspects of her current state, since no one would conscientiously explain the symptoms on the sole basis of estrogen deficit, even though the patient is obviously in the climacterium.

THERAPY[1, 2, 4-9]

The somatic, endocrinological aspect of treatment may be epitomized:

1. The great majority of menopausal women require no endocrine treatment at all.

2. "There is perhaps no gynecological disorder in which the indication for organotherapy is more rational than in the treatment of typical climacteric symptoms, especially of the vasomotor group."[5, 6]

3. The literature contains many such admonitions as Novak's[5]: "The physician who depends upon endocrine therapy alone will fall short of the requirements in many cases, and indiscriminate endocrine therapy certainly should be frowned upon."

In the event that vasomotor symptoms are such as to require therapeutic intervention, there are many effective preparations, natural and synthetic, available. In this regard, it should be kept in mind that "the objective of treatment is the relief of symptoms, not the reestablishment of flowing, nor the reduction in excretion of gonadotropic hormone, nor the alteration of vaginal cytology. Progress of the patient is to be gauged by relief from symptoms, not by any changes in pituitary or estrogenic hormone levels determined in bio-assays."[7]

Often the patient gets considerable relief from the mere telling of her story. Reassurance and educative statements regarding the physiologic nature of the menopause and climacterium will do much to allay the anxiety produced by fear of insanity and loss of sexual activity and prowess. To assist the patient in self-appraisal with a view to strengthening her appreciation of her virtues and accomplishments is ameliorative balm for her narcissistic wounds. Sometimes the physician will be able to detect that the patient has unwittingly passively accepted a life pattern leading to fewer and fewer opportunities for accomplishments of a type meaningful to her. This should be demonstrated to the patient, and ways of reversing this process should be made clear to her. Indicated in such circumstances is a sort of informal occupational therapy, whether it be Red Cross work, gardening, ceramics, canasta, baby-sitting with grandchildren, political activities or whatever, so long as it be something the patient respects or can be induced to respect. The goal of therapy of this kind is to enhance the sense of self-esteem with resulting decrease of anxiety. Wherever possible, activities which involve other people are preferable to solitary occupations, not only because the feeling of "we" is enhanced at the expense of "I," but because the problem of the contracting social circle thus may be solved. In some instances the aid of the children, who in a sense are responsible (by virtue of having established their own independ-

ence) for the decreased self-esteem of the patient, can be enlisted to provide social and recreational opportunities.

The economic security problem is attacked with the greatest difficulty, but increasing civic, governmental awareness of the problems of aging persons has helped to some extent. In the informal occupational therapy sphere such pursuits as baby-sitting, sewing, household hobbies like ceramics, lampshade making, and sale of preserves or cakes may augment decreased economic capacities of the family group, as may more conventional full or part-time employment. These measures can also be supplemented by a "philosophical approach to life" initiated by the physician and an occasional prescription of "uplift literature" like Fosdick's "On Being a Real Person" or Liebman's "Peace of Mind." Books like E. C. Hamblen's "Facts About the Change of Life" and F. S. Edsall's "Change of Life" also are helpful reading for some patients. Local and national mental hygiene organizations have other useful publications along this line.

Some of the secondary changes in sex characteristics which accompany the climacteric can be converted into assets with the complimentary attention of the physician to becoming gray or white hair. Prescription of a weight-limiting diet and mild conditioning exercises to mitigate the tendency to obesity characteristic of this epoch, may temper this natural narcissistic insult.

When an underlying psychoneurotic or psychotic personality structure cannot bear the added burden of the psychosomatic adjustment required by the climacterium, then the assistance of one specially trained to handle psychiatric problems should be enlisted. Generally in the presence of severe anxiety states, hysteria, and melancholia, the services of a psychiatrist are required for more intensive and extensive forms of management. For anxiety states and hysteria psychotherapy offers a favorable prognosis, as does psychotherapy combined with electroshock for melancholic, depressive and suicidal states. It must be emphasized that the climacterium does not, in itself, produce the psychiatric entity but merely may precipitate its frank clinical appearance because the defenses against its emergence, heretofore reasonably successful, cannot withstand the added assault of the new adjustment required of the woman in the climacteric.

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Experiences with Caudal Analgesia in a Small Community Hospital

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SUMMARY

Experience with caudal analgesia for obstetrical patients in a small community hospital, using a technique adapted to the limitations of facilities and personnel, has led to the belief that requirements for the procedure can be met in any good, well-run small hospital.

ANALGESIA and anesthesia in childbirth has been a major problem besetting the obstetricians of the world since the beginning of history. At present it is perhaps the most controversial phase in the field of obstetrics. Prior to the middle of the 19th century but meager efforts had been made to alleviate the pains of childbirth. In 1847 ether and chloroform were introduced in obstetrics. The acceptance of chloroform by Queen Victoria sanctioned the use of anesthesia in childbirth for the general public and this resulted in a great impetus to this entire field of medicine. In 1880 nitrous oxide-oxygen was introduced by Klikowitsch in Petrograd. This was soon followed by the addition of scopolamine and morphine. The use of barbiturates was begun in 1923. During this same period Gwathmey devised the technique of rectal instillation of ether. Tribromethanol (Avertin®) was popular for a short period, and later paraldehyde was used, both rectally and by mouth. The employment of caudal block began early in the century, but even though this technique was used in many cases it fell into disuse for several reasons. In 1940 Hingson and Edwards reestablished the caudal block as a useful procedure in obstetrics and it is largely through their efforts that this technique has become popularized in the past decade.

Spinal anesthesia, which has been employed over a period of years for obviation of pain in obstetrics, recently has come to be used more widely. The Dick Grantly Read method of psychotherapy and relaxation is also being employed in increasing numbers of cases. This approach to labor is one that has much to offer in the handling of any obstetrical case regardless of the type of anesthesia employed. The search for the perfect technique is still in progress and with each new advance an addition is made to the medical armamentarium in the battle with the pain of childbirth.

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Until recently the use of anesthesia in labor has been directed at relieving the mother of pain, with the infant receiving secondary consideration. Obviously in most methods for relieving pain the unborn infant is to a greater or less extent involved in the effects of agents used. Snyder in a recent monograph "Obstetric Analgesia and Anesthesia" has reevaluated this aspect of the problem so that more and more obstetricians are giving increased consideration to the second patient, the infant, in employing anesthesia and analgesia in labor. The criteria of relief of pain combined with complete safety for both mother and unborn infant are ever before us and it is probably true that no one procedure will ever be found that will fulfill all these demands in all cases. It is therefore necessary to evaluate the many factors in each case, in each situation, and select the most advantageous technique for use.

The particular background and environment in which the author confronts the problems outlined differ from the situations to which most trained obstetricians are accustomed. Ten years ago the community in which he practiced was made up of approximately 25,000 people living in the towns of the Monterey Peninsula and the immediately surrounding areas. Hospital facilities for this population were provided by two general hospitals with an effective bed capacity of about 60, in addition to two small nursing-home hospitals which provided an additional ten to fifteen beds. Aside from an occasional home delivery all patients during this period were delivered in these hospitals or at the County Hospital in Salinas. The number of babies born on the Monterey Peninsula in 1938, 1939 and 1940 were 306, 317 and 442, respectively. One hospital (where the fewest infants were delivered) had a resident nurse-anesthetist during the pre-war years who was available to administer general anesthesia for delivery. The other hospitals had no trained personnel for anesthesia and it was the custom for the nurse in charge of the patients in labor to give drop ether for delivery. Occasionally one of the local general practitioners was called in to administer nitrous oxide-oxygen or ether, and in a few cases local anesthesia was employed. During the war years when the number of deliveries increased considerably and the number of physicians decreased, it was nearly impossible to have a physician anesthetist for uncomplicated cases.

Since the end of the war the population of the Monterey Peninsula has reached an estimated 60,000. The numbers of births for the years 1945

to 1949 were 1,035, 974, 1,142, 1,341, and 1,612 respectively. The number of available private hospital beds has increased to 90, and in addition there is an obstetrical service at the Fort Ord Station Hospital which provides hospitalization for wives of armed service personnel. During this period there has developed a group of physician anesthetists. Three of the group are general practitioners who have had more or less specialized training in anesthesia, and there is one whose practice is limited to anesthesia. One or more of these physicians is usually available for the administration of anesthesia to obstetrical patients.

It is well known that the average obstetrical patient is a poor subject for general anesthesia. The patient frequently arrives at the hospital after a full meal and often is emotionally upset and apprehensive. The nasal passages may be congested from crying during labor, and at best the anesthetist regards the obstetrical patient with misgivings. That there have been only rare serious anesthetic accidents in the author's experience is more good fortune than a result of ideal working conditions.

The use during labor of analgesics such as barbiturates, scopolamine, and Demerol,® in addition to general anesthesia for delivery, increases the incidence of anoxia and asphyxia in the newborn. In the author's experience there have been only a few cases in which such effect on the infants has been pronounced, possibly because an attempt has been made to use medication in moderation. Nonetheless, it is easy to see that conditions for mother, infant, obstetrician and nurse were far from ideal.

With this background in mind, it was decided to establish the use of caudal analgesia and anesthesia as a technique in the care of selected patients for labor and delivery in an effort to avoid some of the previously mentioned problems.

Several features of caudal analgesia seemed attractive. Primarily, it avoided general anesthesia which has always seemed particularly hazardous in obstetrics, both for mother and infant. It offered a maximum of pain relief to the patient in labor with a minimum of effect on the infant. The chief problem seemed to relate to the modification of the technique as used in large institutions to make it practicable in a small hospital. There were several factors in the local situation which were not commonly present in institutions from which success with the use of caudal analgesia had been reported. By the time the use of caudal analgesia and anesthesia was decided upon, all hospital care was limited to the two general hospitals, but these are small and have only partially organized obstetrical departments. There are no residents or interns, and the nursing staff, while adequate, is somewhat limited as would be expected in a hospital where no more than ten to twelve beds are allotted to obstetrical patients. In addition the delivery rooms are adjacent to the surgery suite rather than being an integral part of the obstetrical wing.

The problem, then, was one of planning the procedure in such a way that after the anesthetic was administered and established, the patient could be safely and easily supervised by a registered nurse.

After consultation with members of the department of anesthesia at Stanford University School of Medicine, a procedure with pontocaine solution as a single injection block was adopted. Epinephrine was added to a 0.15 per cent solution of pontocaine to prolong the relatively long action of the drug. The intermittent or single injection technique was followed rather than the continuous method because of the minimum amount of medical and nursing supervision required in the former procedure. Trials were made with inlying malleable caudal needles and the catheter technique, but as it was found this increased the problems of the supervising nurse with the only advantage gained being the avoidance of reinsertion of the needle for repeated injections, these techniques were abandoned. Not infrequently the malleable needle became dislodged and reinsertion of the needle for reblock was required anyway. It was also found that it is easier technically to insert a non-malleable spinal needle than the malleable caudal needle and that as experience increased skill improved and the problem of reinsertion of the needle for reblock became minimal. The patients themselves were happier and less apprehensive when the needle was removed at the end of each injection. The only accident encountered with a needle resulted from moving a patient with an inlying malleable caudal needle, which broke below the hub. It was retrieved without difficulty, but the experience emphasized that the presence of such a needle does bring special problems and does require more care and supervision of the patient than the other procedure.

It is routine to use one of the barbiturates prior to the pontocaine injection. Usually 0.1 gm. to 0.2 gm. of Nembutal® along with 0.065 gm. of codeine or 50 mg. of Demerol® is given fairly early in the first stage and this usually provides adequate sedation to carry the patient to the time when the caudal anesthetic is administered. In cases in which the cervix dilates slowly it is sometimes necessary to give some additional sedation before the anesthetic is given. The patient is placed in a modified Sims's position, the area is prepared with tincture of merthiolate, and a 20-gauge 2½- or 3-inch spinal needle is inserted into the caudal canal. Test aspiration is done to make sure that the subarachnoid space has not been punctured, and a 6 to 8 cc. test dose of 0.15 per cent solution of pontocaine is injected. After a wait of ten minutes the patient is observed for signs or symptoms of subarachnoid injection. None being found, the effective dose of anesthetic solution, usually 25 cc., is injected. When caudal anesthesia was first employed, the total dose was varied according to the height of the patient, but undesirably high levels of anesthesia were obtained in some cases, and it was found that there was generally little correlation between the patient's height and the anesthetic effectiveness of a standard dose. With a 25 cc. injection the incidence of high levels of anesthesia, and attendant complications, has been

cut to nil and the number of times that this amount of anesthetic mixture is insufficient for adequate analgesia is low. Following the injection the patient is returned to her back, the head is elevated slightly and a pillow is placed under the knees. The blood pressure and pulse are observed at frequent intervals. A decrease in blood pressure of 10 to 20 mm. of mercury is not unusual. If the systolic blood pressure falls to 100 mm. of mercury, a circulatory stimulant is administered. A pronounced decrease in blood pressure can lead to an anoxic state in the infant. A systolic blood pressure of 80 mm. is considered essential to provide adequate oxygen supply to the infant. Ephedrine or Neosynephrine® is usually employed for stimulation, and use of these drugs is repeated if indicated. Rarely are there signs of oxygen want, but when this exists, oxygen inhalations are given. The regularity and duration of uterine contractions are carefully observed.

It is the rule that the attending physician remain with the patient for a minimum of 45 minutes following the caudal injection. If, as is usual, at the end of this time the anesthetic level is established, the blood pressure is stabilized and the condition of the patient is satisfactory, the physician may leave the continued care and observation of the patient to the nurse in charge of patients in labor. If a return of pain is noted by the patient, a reblock may be carried out in the manner previously described.

When this method was first employed, patients were selected according to the usual indications and contraindications listed in the literature. It is no doubt true that, in initial enthusiasm for the method, the procedure was employed in some cases in which another method might have been better. That the method is only being used now in about 50 per cent of the cases, whereas during the first year it was employed in about 73 per cent of the cases, is not so much a reflection on the value of the technique as it is evidence of the realization of the great importance of careful selection of patients. Three years ago, where no contraindication existed, caudal analgesia was employed in patients in active labor with the cervix dilated to about 4 cm. Now the anesthetic agent is not introduced until dilation has reached 5 to 6 cm. This is done because, contrary to the reports in the literature, it is felt that there is a definite tendency for the progress of labor to slacken when analgesia is established early (4 cm. dilation or less). As a result of this postponement of the administration of the caudal block, there are a number of cases, especially in multiparae, in which progress is so rapid from the 5 to 6 cm. dilation stage to complete dilation that there is insufficient time to use the caudal technique. This is one of the factors in lowering the percentage of cases in which caudal analgesia is used. The author has become wary of this procedure for women in whom there is any sign of uterine inertia; and if caudal anesthesia is used at all in such circumstances, it is deferred until the end of the first stage of labor or the beginning of the second.

Patients who have no deep-seated apprehension with regard to it have been encouraged to permit the use of caudal analgesia, but it has not been urged upon anyone who was definitely opposed to it, save possibly in the case of premature labor in which the avoidance of general anesthesia is such a definite advantage to the premature infant.

Breech presentation is considered by some physicians to be a contraindication to the use of caudal analgesia; the increased tonicity of the uterine musculature is thought to increase the difficulty of breech delivery. However, the author in using this procedure in breech presentations has noted that the relaxation of the pelvic floor seems to make delivery easier.

At first caudal anesthesia was used in cesarean section, but the time consumed in establishing the anesthetic level and the relatively high percentage of cases in which anesthesia was inadequate was found to be a distinct disadvantage in cases of this type. Now, weighted spinal anesthesia is used for abdominal delivery.

As the number of deliveries in which this procedure was used—between 500 and 600—is small compared to the many large series reported in the literature, it would seem to add little to make a statistical analysis of the series. The author has found that success with the procedure has increased as skill in its administration has improved. The majority of failures can be attributed to failure in the proper placement of the needle in the caudal canal. There was a small number of patients in whom the anesthetic agent seemed to have no effect and a few in whom a satisfactory anesthetic level was not obtainable, but in general it can be said that failure to establish adequate analgesia generally resulted from failure in the administration, not in the procedure itself.

With the technique previously outlined employed, it is usually found that within 30 to 45 minutes the anesthetic level is established at about T-9 or T-10. Sometimes the frequency and duration of the uterine contractions diminishes noticeably, indicating that some of the motor fibers have been involved in the anesthesia. The author has found that the use of small doses (2 minims) of obstetrical Pituitrin® or Pitocin® are effective in counteracting this effect, and there have been no untoward reactions from the use of such uterine stimulation.

The duration of effective analgesia averaged three hours, with an occasional shorter period and a few cases in which anesthesia lasted four hours or more. Usually by the end of this time, if not before, dilation is complete and the presenting part is low, if not actually on the perineum. A reblock is then done if necessary and the baby is delivered.

There have been but four instances of puncture of the subarachnoid space, three of which were immediately noted as the spinal fluid flowed from the end of the needle on removal of the stylet. In those cases no further attempt was made to use caudal anesthesia. In the fourth patient, in spite of the rou-

tine procedures to avoid subdural injection (aspiration of the needle, ten-minute wait after the administration of the test dose, and further attempts at aspiration before injection of the full dose, questions to elicit symptoms of spinal anesthesia from the patient) there developed a rapidly ascending spinal anesthesia with respiratory arrest following the injection of the full effective dose. Artificial respiration for three hours was necessary. Fetal death occurred in this case, but it was the only one in the series which could be attributed to the anesthetic procedure. This case was the only one in the series in which there was serious complication. Rapid drainage of the spinal fluid might have speeded the recovery of the patient.

Forceps delivery was carried out in practically all cases. This is in agreement with reports by other investigators. In a very high percentage of cases the baby breathes or cries before delivery. Because of this prompt initiation of respiration, it is essential to take care to wipe out the mouth or aspirate the mucus from the mouth as soon as the head is delivered, and before the remainder of the delivery is carried out, to prevent aspiration of fluid into the lungs.

Occiput rotation is more frequently required with caudal than with inhalation anesthesia, but the ease with which this is done when the soft parts are completely relaxed more than compensates for the higher incidence.

While no accurate studies have been made in this regard, it is the author's clinical impression that the loss of blood at delivery is not appreciably reduced with the use of caudal analgesia. This is contrary to the reports in the literature.

In the present series there were no cases of infection resulting from the use of caudal analgesia and there were no instances of postanesthesia nerve involvement.

CONCLUSION

In conclusion it seems safe to say that caudal analgesia is a useful and valuable procedure in the practice of obstetrics when used with care and proper supervision in carefully selected patients. The author is satisfied that the requirements for the administration of caudal analgesia can be met in any good, well-run small hospital.

The advantages offered by caudal analgesia are several:

1. It is possible to carry the patient through the latter part of the first stage and second stage without heavy sedation and its potential undesirable effects on the infant. Most patients tolerate labor better when they feel assured that the latter stages will be painless.

2. The prompt vigorous cry of the infant is in pronounced contrast to the more delayed, less active cry of the infant whose mother has been heavily sedated during labor and is under general anesthesia for delivery. Where it is not always easy to have the services of a trained anesthetist, avoidance of general anesthesia is a distinct advantage.

3. Patients under caudal anesthesia are much easier to care for in labor; there is less tension on the part of the nursing staff, and fewer hurry calls for the physician, which in a small hospital without a resident staff is a distinct advantage.

The disadvantages of caudal anesthesia are few but definite:

1. It is a comparatively difficult technical procedure and requires practice to administer successfully.

2. It is potentially dangerous because of the injection of large amounts of anesthetic agents which, if through error they enter the subarachnoid space, may lead to death.

3. It necessitates operative deliveries in most cases, so that it ought not be used by physicians who are not qualified to perform them.

4. It is time-consuming for the attending physician.

Low spinal anesthesia has several advantages not possessed by caudal anesthesia. It is simpler and, because only small amounts of anesthetic agent are employed, it is not potentially as dangerous. Its use for analgesia in the first stage is limited. The problem of postanesthesia headache has been an annoying one in the author's limited experience with spinal anesthetic. This relatively minor complication has caused so much discomfort to such a large proportion of cases that the author prefers not to use this technique if caudal anesthesia is at all feasible.

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The Physician and Workmen's Compensation Cases

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THIS discussion is directed to physicians who are either just entering the field of industrial surgery or who do varying amounts of industrial surgery concurrently with private practice. Physicians who have long specialized in such work are well acquainted with most, if not all, of what is to be covered in the following paragraphs.

Prior to 1913, there was no such thing as a Workmen's Compensation Act in the State of California. The working man's only hope for redress from industrial injuries was through the processes of civil courts. In that year, the original law was established, setting forth the responsibilities of the physician and of the employer to the employee in the event of injury—the establishment of weekly compensation benefits, recompense for permanent disabilities resulting from injury, and many other factors. Various parts of the law were revised as time passed. Any physician interested in building an industrial practice should become well acquainted with the material contained in the two books, "Industrial Accident Commission and Procedure" by Warren L. Hanna, and "Compensation Law" by Douglas L. Campbell.

Many physicians who are new to industrial practice or who only occasionally treat a patient for industrial injury or illness, object to the amount of so-called "paperwork" which is required. However, it should be realized that this is not the whim of some insurance company, but is a necessity for the protection of the interests of the patient, the physician and the compensation insurance carrier. Before the patient can be given any weekly compensation, the law requires that the insurance company have a first surgical report of the accident from the employer, verifying the accident. This report must be made on a special form provided by the Industrial Accident Commission. Since the law of the state further requires that, on advisement of injury to an employee, the insurance company must prepare to take care of the injured man in the form of medical expenses and temporary disability payments, it can readily be seen that accuracy in description of the injury, proper estimation of the period of temporary disability, and early advisement of the degree of probable permanent disability are absolutely essential. Even though it is in many cases difficult, an opinion as to temporary and permanent disability must be given, and the attending physician is the best judge of this. It is understood that prognosis may change as a case progresses. The physician should include all the complaints of the injured person in his reports, not minimizing the condition or complaints, nor be too optimistic as to end results, for it is imperative that the insurance company have adequate information to set up reserves to cover the cost of the case. In cases in which he is not positive of the condition, the physician should be careful about giving diagnoses in writing his first report of injury. As a week or more may elapse before another specialist has opportunity to examine the injured person, the diagnosis made by the first physician would carry considerable weight in any later disposition of the case.

Most persons who are receiving compensation are in some degree embarrassed financially, and it is therefore important that the compensation payments be made regularly and promptly. Inasmuch as such payments are based upon medical opinion as to disability, it is both the legal and moral duty of the attending physician to keep the compensation carrier advised of the patient's condition and progress. These progress reports (on blanks furnished by each insurance company) permit the insurance carrier to pay compensation promptly and continue payments during disability.

LEGAL FACTORS

Frequently question arises as to the legal relationship of the physician to the patient, and to the insurance company, as differing from that of ordinary physician-patient relationship. The only difference is that the law of privileged communications is waived by the patient insofar as the compensation carrier and physician-relationship is concerned. If a physician does not wish to make an examination, or send a report, or make a diagnosis in any case in which to do so would embarrass or affect him in the community in which he lives, he should notify the insurance company so that it may have the injured person examined by a physician who can give an opinion without detriment to anyone.

It should be remembered that the insurance companies are bound to pay any and all legitimate claims, but can only do so with the cooperation of the physician in charge of the case. Prompt and accurate reports are necessary, and the physician should communicate with the insurance carrier by telephone, letter, or telegraph in all critical cases or where there is doubt concerning proper procedure, and in all cases where there is a question of the relationship of the injured person's condition to his occupation. This permits the carrier to advise regarding procedure or to obtain consultation. In all

legitimate claims, the interests of the physician, patient, and insurance company are identical—rapid recovery, and good end results from the injury sustained.

Frequently the physician will confront a case of injury in which preexisting disease is present, or in which the diagnostic picture is confused by a non-occupational injury or coincidental illness. Many persons have physical defects of which they are not cognizant, but which may eventually progress to a stage at which symptoms develop. This may occur while the person affected is working or at home. It is also possible for an injury at work to aggravate an unrecognized ailment. The patient's interests in such circumstances are best served if the attending physician determines the true relationship of all these factors and weighs them carefully in formulating an opinion. This opinion must be based upon the facts obtainable and according to the compensation law, not upon what the physician feels the law should be. In "problem cases" of this kind, and in all serious cases, the insurance carrier is usually anxious to afford consultation and the help of specialists.

The Compensation Act requires that an injured man be given a release to work when, in the attending physician's opinion, he is physically capable of returning to work insofar as his industrial injury is concerned. The fact that a patient may have developed an unrelated and disabling medical condition in the interim does not alter the physician's responsibility relative to notification regarding the work status of the patient with regard to industrial injury. It is also required that any condition which in the physician's opinion might cause permanent disability must be reported. When a patient is able to return to light work (partial temporary disability), it is well to advise the insurance carrier that such is the case, since in many cases it may be found that the employer has such work available. Often this will permit the injured employee to return to a better economic status and be of definite benefit from the standpoint of patient morale. As light work may also be of medical value, in some cases it is better than occupational therapy for the same purpose.

CLASSIFICATION OF DISABILITIES

There are two major classifications of disability —temporary, and permanent, in each of which are two sub-classifications:

A. Temporary disability. (In this classification, decisions affect the size and duration of continuing compensation payments.)

1. Total: This indicates that for the time estimated or verified by the attending physician, the patient is incapable of carrying out any form of work.

2. Partial: The patient is not fit to assume all the duties of his regular work, but could assume a part of them or return to light work.

B. Permanent disability. (In this classification, concern is with permanent disability ratings or settlements.)

1. Total: The patient is physically handicapped to such a degree that he will permanently be unable to resume any form of gainful employment. Such cases are in the minority.

2. Partial: Some degree of permanent physical handicap from injury exists which will limit the patient's working ability in one form or another.

A few of the common factors which continue to cause difficulty in compensation cases are:

1. *X-rays:* X-ray studies are indicated wherever such a procedure will further or clarify diagnosis. It is unnecessary to dwell upon the seriousness of neglecting to take adequate x-ray films, since, for example, it can readily be understood that failure to diagnose a fracture early will usually result in less satisfactory reduction and increased disability. The value of comparative x-rays of like parts, in cases in which the presence of pathologic change is questionable, should not be overlooked.

2. *Incomplete histories:* There are certain fundamental facts which must be obtained to arrive at a logical conclusion. A complete history need not be a long one.

3. *Incomplete diagnosis:* Inaccurate diagnosis may result in prolonged temporary disability, and increased permanent disability.

4. *Anomalies:* The following are common anomalies and processes which may be mistaken for injury: Bipartite sesamoids; failure of fusion of base of fifth metatarsal bone; failure of fusion of medial tip of tarsal scaphoid; os trigonum; Osgood-Schlatter's disease; failure of fusion of transverse process of vertebra, L-1; old ununited chip or "sprain" fractures about joints; epiphyseal lines in young adults.

5. *Tendon and nerve injuries:* In all cases of lacerations, especially in the hand, careful examination to determine the exact tendon and nerve involvement is extremely important. One should not forget the possibility of rupture of the biceps tendon without laceration.

6. *Splinting:* The not uncommon practice of "tongue-blade" splinting of fingers results in such pronounced functional disability, if any stiffness occurs, that it is to be condemned. There are very few cases in which the involved digits cannot be immobilized in the semiflexed position with more satisfactory results. The same penalty results from immobilizing the ankle in a position of plantarflexion. Resultant stiffness in this position gives a high degree of permanent disability. Other joints should be splinted in the position of maximum function unless this is definitely contraindicated by some unusual situation.

7. *Rating for permanent disability:* When an injury results in permanent disability, it is the duty of the attending physician, when maximum improvement has occurred, to fill out permanent dis-

ability rating forms. However, the law requires that these forms are not to be completed until, in the physician's opinion, there will be no change for better or worse in the condition as further time passes. Statements made in filling out these forms should not be speculative, but should be based on objective findings. A reprint from "Industrial Accident Commission Practice and Procedure" entitled "How to Examine for Disability Rating Purposes" is available through the Industrial Accident Commission. This gives a very clear and comprehensive description of the proper procedure and methods of measurement used in preparing such forms. It is essential to fill out all details of the form and to utilize diagrams on the reverse of the blank to give a definite picture of the patient's condition, since the rating board does not see the patient in person.

Insofar as subjective complaints are concerned, all complaints given by the patient should be listed. However, if the physician feels that any of the complaints is not justified by the findings, he should so indicate under "Remarks" on the rating form.

It should be remembered that when a question or doubt arises concerning procedure or other factors in a case, the answer to the problem usually can be obtained by communicating with the insurance carrier.

From both the humanitarian and economic standpoints, the injured workman deserves the best possible medical care. As industry has increased, recognition of the importance of good medical care has come to the employee, the various labor unions, and the employer. Owing to the persistent efforts of most of the physicians in industrial practice, the stigma of the title "company doctor" is gradually fading. Continued effort to improve the medical care given to persons injured in industry is necessary if industrial practice is to acquire the status which this specialty deserves. The quality of treatment must be as high as is that given patients in private practice.

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This is the first of two articles on the role of the physician in industrial compensation cases. The second, dealing with evaluation of subjective complaints, will appear soon in CALIFORNIA MEDICINE.

Perforated Gastric and Duodenal Ulcers

An Analysis of 73 Cases

FRANCIS L. GASPARINI, M.D., and THOMAS K. HOOD, M.D., *San Francisco*

SUMMARY

In 73 cases of perforated gastroduodenal ulcers in which operation was done at St. Joseph's Hospital, San Francisco, during the ten-year period July 1939 to July 1949, the death rate was 13.7 per cent. In all but three of the cases, simple closure of the perforation was carried out.

In 46 cases there were postoperative complications. Of this number, peritonitis and its sequelae comprised 35 per cent and pulmonary complications, 37 per cent. The mortality rate in the group in which these complications occurred was 35 per cent.

THE present study comprises an analysis of 73 consecutive cases of perforated gastroduodenal ulcers in which operation was carried out at St. Joseph's Hospital, San Francisco, during the ten-year period from July 1939 to July 1949. All were private patients and the operations were done by one or another of 21 surgeons.

The group includes only those cases of benign gastric and duodenal ulcers with free intraperitoneal perforation. Cases of subacute perforation and penetrating ulcers of the gastrohepatic omentum and pancreas, as well as those in which there was rupture into the gallbladder and other adjacent viscera, have been omitted.

The study was undertaken primarily to determine the incidence of complications in patients treated surgically, and to compare the mortality rate with rates reported in larger series of cases.

Age. The youngest patient was 24 years of age and the oldest 75. There were 22 per cent in the fourth decade, 30 per cent in the fifth and 29 per cent in the sixth (Chart 1). Shipley and Walker,[6] in an analysis of 200 cases, reported 25 per cent of patients in the fourth decade, 27 per cent in the fifth and 22 per cent in the sixth.

Sex. Ninety-seven per cent of the patients were males.

Season. Perforations occurred with equal frequency during spring, summer, fall and winter. This agrees with observations reported by Estes[2] and DeBakey.[1]

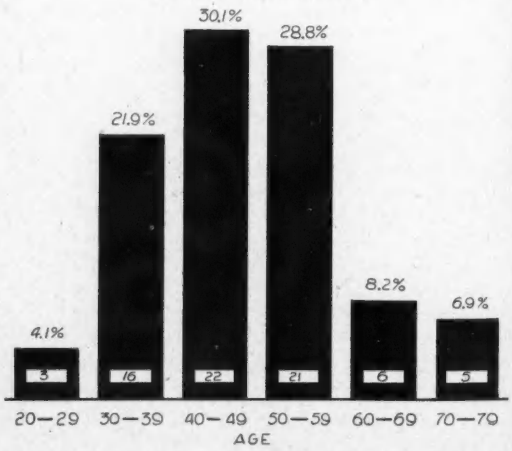
Occupation. Repeated surveys relating the occupation of patients to perforated ulcer have indicated that laborers are the most likely victims. Walton[8] reported 50 per cent of patients were laborers, while Fallis[3] in an analysis of 100 cases noted that 63 per cent of patients were laborers. In the present study, laborers represented 36 per cent of the group.

Location. Approximately 60 per cent of the perforations occurred in duodenal ulcers and 39 per cent in gastric ulcers.

Eighty-six per cent of the patients on whom a complete history was available for review complained of one or more symptoms referable to the gastrointestinal tract prior to the occurrence of perforation. These included hiccoughs, epigastric fullness, gnawing upper abdominal pain, nausea, vomiting (with or without blood), eructation, postprandial distress and tarry stools. Symptoms occurred singly or in varied combinations and had been present for from several hours to several months. More than half of the patients were assertedly following a regimen for relief of peptic ulcer at the time of perforation, and it is of interest that a majority of them did not rigidly adhere to dietary restrictions and instructions as given them by a physician. In other cases the regimen of therapy, as related by the patient, was wholly inadequate as compared with modern standards of ulcer management.

Twenty per cent of the patients had eaten a meal from one to three hours preceding perforation or had ingested alcoholic beverages. One female patient fasted for five days while on an alcoholic bout. In ten per cent of cases the perforation occurred while the patient was at work, and in one case after the patient was struck in the abdomen by a board. Six per cent of the patients were awakened from sleep by severe upper abdominal pain. In two cases the perforation occurred when the patient was in bed in the hospital. In no case did perforation occur during fluoroscopic examination of the stomach after barium meal.

Chart 1.—Age incidence.



From the Department of Surgery, St. Joseph's Hospital, San Francisco.

TABLE 1.—*A Comparison of Mortality with the Interval of Time (in Hours) Elapsing Between Perforation and Operation*

Time Interval Between Perforation and Operation (Hours)	No. of Cases	Per Cent of Series	No. of Deaths	Mortality Rate (Per Cent)
0 - 10	39	53.4	3	7.7
10 - 25	18	24.7	5	27.7
Over 25	8	10.9	2	25.0
Unknown	8	11.1	0	.....

In over 90 per cent of cases the symptoms of perforation consisted of sudden onset of severe upper abdominal pain followed by nausea and/or vomiting. The pain was most frequently described as knife-like, stabbing or cramping in character, often causing the patient to double up. A few patients were reported to have "collapsed" or fainted shortly after the attack of pain.

The time elapsing between perforation and operation was less than ten hours in 53 per cent of the cases, and in 25 per cent it was ten to 25 hours (Table 1).

Eighty-five per cent of the patients gave no history of previous perforation. Eight per cent had had one previous perforation.

The preoperative diagnosis was made correctly in 69 of the 73 cases (94 per cent). Shipley and Walker[6] reported correct diagnosis in 95 per cent. The four erroneous diagnoses were appendicitis, strangulation obstruction of the small bowel, acute pancreatitis and acute cholecystitis.

Leukocytosis with a high percentage of polymorphonuclear cells is common in the presence of perforated ulcer, and this condition may be well established as early as one hour after the onset of symptoms. Absence of leukocytosis, however, by no means excludes the diagnosis of perforated ulcer. The leukocyte content of the blood was determined in 69 cases. In one case leukocytes numbered 5,000, in 14 between 5,000 and 9,000, in 20 between 10,000 and 14,000, in 14 between 15,000 and 19,000, and in 20 over 20,000. Closely paralleling the increase in leukocytes was elevation in the number of polymorphonuclear cells. In 55 of the 69 cases, the proportion of polymorphonuclear forms was over 85 per cent; in 31 cases it was between 90 and 95 per cent.

Blood Pressure, Pulse and Temperature. In most of the patients there was little or no clinical evidence of shock upon admission to the hospital. In 46 cases in which the blood pressure was recorded, there were eight in which the systolic pressure was less than 110 mm. of mercury. In three patients the systolic pressure was less than 100 mm. of mercury; perforation had occurred, respectively, 14 hours, 13 hours, and 6 hours previously.

Sixty-two per cent of the patients had a pulse rate of less than 100 per minute at the time of admission, and 39 per cent had a rate of between 80 and 90 per minute. In 22 per cent the rate varied between 100 and 110, and in only 14 per cent was it over 110.

That the temperature is not appreciably affected by the length of time which has elapsed from perforation to admission to the hospital is indicated by the fact that 84 per cent of the patients had temperature of less than 100° F. upon admission.

Pneumoperitoneum. The demonstration of free intraperitoneal air by a scout film of the abdomen with the patient in either the erect or left lateral decubitus position is an important aid to the diagnosis of perforated ulcer.

Roentgenograms were taken in 52 cases. Pneumoperitoneum was demonstrated in 88 per cent of them. Treiger[7] reported observation of free intraperitoneal air in 60 per cent of cases in which x-ray films were made, and McNealy[4] stated that pneumoperitoneum was observed in 77 per cent of 374 cases of perforated ulcer in which fluoroscopy was done. Pneumoperitoneum was not demonstrated roentgenographically in six of the 52 cases in the present series in which x-ray examination was carried out. In four of the six the perforations occurred in duodenal ulcers, and in two in gastric ulcers; in three cases the perforation had been present less than six hours, and in three between six and 20 hours at the time the films were made.

Anesthesia. Seventy-nine per cent of the patients received general anesthesia, 13 per cent spinal anesthesia, 5 per cent spinal anesthesia supplemented with gas, and 1 per cent local anesthesia supplemented with gas. It may be significant that all deaths occurred in the group given general anesthesia.

In 13 cases in which operation was done after 1948, no deaths occurred. Two factors may well share credit: (1) At the beginning of this period, a fully competent department of anesthesiology was organized at St. Joseph's Hospital, and (2) penicillin and other antibiotics were used in adequate dosage and prophylactically rather than for treatment of complications after they set in.

Drugs. The antibiotic agents used in 35 cases included sulfadiazine, sulfathiazole, sulfanilamide and penicillin. There was no significant difference in mortality rate as between patients given penicillin, those who received the sulfa drugs and those for whom chemotherapy was not employed. It was found, however, that during the earlier years of the use of penicillin, therapy was usually instituted after complications were established, and the dosage administered was one-sixth to one-tenth the amount now regarded as adequate.

Complications. Forty-six postoperative complications occurred in the series (Chart 2). Of this number, peritonitis and its sequelae comprised 35 per cent and pulmonary complications 37 per cent. Wound infection and disruption (including two

TABLE 2.—*Per Cent of Total Mortality in Patients Receiving the Sulfa Drugs and Penicillin*

	No. of Cases	No. of Deaths	Mortality Rate (Per Cent)
Sulfadiazine, Sulfathiazole, Sulfanilamide	12	2	20
Penicillin	23	5	50
No drugs used	38	3	30

CHART 2.—POSTOPERATIVE COMPLICATIONS.

	NUMBER OF CASES															PER CENT
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
PERITONITIS	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	32.6
PNEUMONIA	■	■	■	■	■											10.9
PNEUMONITIS	■	■	■	■	■	■	■	■								17.7
MASSIVE ATELECTASIS	■															2.1
PARTIAL "	■	■														4.3
HYDROPS - GALLBLADDER	■															2.1
DUODENAL FISTULA	■	■														4.3
WOUND DEHISCENCE	■	■	■													6.5
" ABCESS	■															2.1
LOWER NEPH. NEPHROSIS	■															2.1
FECAL IMPACTION	■	■														4.3
CORONARY THROMBOSIS	■															2.1
EDEMA - LARYNX	■															2.1
OBST. SMALL BOWEL	■															2.1
SUBPHRENIC ABCESS	■															2.1
PULMONARY INFARCTION	■															2.1

cases of partial separation of the wound incident to duodenal fistula) made up 13 per cent of complications.

Forty-four (60 per cent) of the 73 patients in the series were free of postoperative complications following suture of the perforation. The interval of time from perforation to surgical intervention in 15 of the cases in which there were no complications was 10 to 18 hours. In two cases the interval was longer—28 hours in one and 30 hours in another. Of the 29 patients (40 per cent of the series) who had complications, 79 per cent had some degree of peritonitis and/or pulmonary complications. The time elapsing from perforation to surgical repair in this group was less than six hours in nine cases, 15 to 25 hours in ten cases, and above 25 hours in four cases. The mortality rate in patients with these complications was 35 per cent. It would appear, therefore, that the time interval between perforation and operation is not necessarily a contributory factor in the incidence of postoperative complications. As to mortality rate, however, it is equally obvious (Table 1) that the rate was considerably less in the cases in which operation was done within ten hours than in the cases in which the interval was longer.

The postoperative temperature record in cases of pulmonary or intraperitoneal infection was of interest. Generally the patient with pulmonary infection had a rapid rise in temperature to a range of 101° F. to 103° F. within the first 48 hours after operation. In subjects with primary peritonitis, the fever curve became significant in from three to eight days postoperatively, and the rise was gradual. This would indicate that when there is a sudden elevation of temperature within 48 hours after operation, pulmonary infection is the most likely cause.

Mortality Rate. There were ten deaths, a mortality rate of 13.7 per cent. McNealy and Howser[4] reported a mortality rate of 27 per cent in 700 cases they reviewed. Paletta,[5] in summarizing 26 series totaling 7,564 cases, found an average mortality rate of 26.8 per cent, while in a series of 83 cases he himself reported, the mortality rate was 17 per cent.

Five of the ten deaths were caused by peritonitis, two by pulmonary complications, and one each by duodenal fistula, shock and coronary thrombosis. Two of the ten patients who died were in the age group 30-40 years, five in the 40-50 group, two in the 50-60 group, and one in the 60-70 group.

The postoperative hospital period in 64 per cent was not greater than 15 days.

490 Post Street.

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Intracranial Tumors Simulating Vascular Lesions of the Brain

A Preliminary Report

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SUMMARY

Occasionally in the presence of atypical symptoms it is difficult to distinguish between cerebrovascular disorders and intracranial tumors. Intracranial tumor should be suspected in cases of atypical symptoms of vascular lesion or even in typical cases in which the patient does not show expected improvement.

In a group of eight cases the problem of differential diagnosis was not confined to those in which the patients were elderly. Furthermore, papilledema and elevated spinal fluid pressure were absent in all these cases. The absence of these signs, therefore, does not eliminate the possibility of an intracranial tumor.

The electroencephalogram is an important adjunct in differentiatial diagnosis. In this series, electroencephalograms lateralized the lesion correctly in every case and localized it in one. The importance of repeated electroencephalographic examination if wave patterns are normal in the first tracing was clearly illustrated in three instances.

Ventriculography, which in six cases finally established the diagnosis, and the site of the lesion, should not be postponed unnecessarily.

OCCASIONALLY encountered is a case in which, although all the earmarks of vascular lesion are present, the final diagnosis is intracranial tumor. Differentiation is especially difficult if there are manifest signs of peripheral and retinal arteriosclerosis or evidence of hypertensive-vascular and cardiorenal disease associated with indications of intracranial dysfunction. Even in those instances in which these signs are not present, but in which progressive hemiplegia with sensory impairment and mental changes occur without evidence of increased intracranial pressure, vascular lesion may be suspected. At times a glioma may remain silent for some time, then provoke a sudden apoplectic attack, so that the lesion may be mistaken for a cerebrovascular disorder.

Such problems in differential diagnosis have been a not uncommon experience at the Institute of Nervous Diseases. Within the past few years there have been a number of cases in which the tentative diagnosis was cerebrovascular accident, but in which an intracranial tumor ultimately proved to be the cause of the cerebral symptoms. For this reason it was thought to be of both interest and value to review the pertinent data and records of a selected group of eight of these patients in an effort to determine the sources of error in diagnosis. In this study an attempt has been made to evaluate certain features in the clinical history which have proven to be of differential value. Emphasis has also been placed on such special examinations as have served to establish the correct diagnosis.

There are not many reports in the literature on the subject of the simulation of cerebral vascular lesions by intracranial tumors, but it is clear that other investigators have had difficulty in differentiation. Hastings[2] reported 25 cases of intracranial tumor in which the cardinal symptoms of headache, vomiting, and choked disk were absent in a varying degree of 65, 76, and 100 per cent, respectively. In the circumstances, and since the patients were all 40 years of age and older, tumor was not suspected in any of the cases.

In considering the problem, Rabiner[4] pointed out that the gradual involvement of the motor control of one side of the body is indicative of a true cerebrovascular accident, whereas "piecemeal" hemiplegia, involving first one limb and then spreading to the face and the other limb, suggests an expanding lesion. He also concluded that Jacksonian seizures rarely, if ever, are produced by primary vascular disease.

The similarity of the symptoms produced by intracranial tumors and those caused by cerebrovascular disease was illustrated in a report of two cases by Arenson and Ginsberg[1] in which the tumors were masked by cerebral arteriosclerosis. These investigators stressed the importance of frequent examinations of the ocular fundi and of spinal punctures, as well as the use of x-ray examination of the skull, particularly after the injection of air.

Marshall[3] reported a series of 17 cases of intracranial tumor in which an erroneous diagnosis had been made. The conditions simulated were many, varying from hysteria to toxic psychosis and including such vascular lesions as cerebral arteriosclerosis, hemorrhage, and softening incident to thrombosis of the larger cerebral arteries. Marshall concluded that one reason for the failure to make the correct diagnosis was a lack of "brain tumor consciousness." Apparently electroencephalographic examination had not been used in any of the cases. The value of roentgenologic examination of the skull and a study of the dynamics of the cerebrospinal fluid was stressed.

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Weisz[5] reached the conclusion that definite clinical criteria cannot be laid down and that each individual problem must be evaluated according to the facts at hand. He stated that a critical study of detailed chronological data will often suggest either a tumor or a vascular lesion and that the diagnosis of the latter should not be considered established unless the results of examination and the clinical course are consistent with cerebrovascular disorder.

In the following section, an effort has been made to epitomize the essential features in eight cases in which the more important clinical problems encountered by the author occurred:

CASE 1: A white woman, 45 years of age, complained of unsystematized dizziness, left frontal headaches, left-sided paresthesias, and a poor memory for five weeks. When a mild degree of anomia and motor aphasia together with anisocoria and a right lower facial weakness were found to be associated with positive reaction for syphilis in a Wassermann test of the spinal fluid, the diagnosis of multiple vascular lesions incident to meningovascular syphilis seemed most likely. The presence of a tumor, possibly metatastic, was considered, however. The patient became progressively worse on a program of antiluetic therapy. An electroencephalogram showed focal dysrhythmia and phase reversal activity in the left temporal lobe. A ventriculogram indicated an expanding lesion in the left temporal lobe; a glioma (ganglioglioma) was observed at operation and was incompletely removed.

Comment: The symptoms suggestive of multiple lesions and the initial positive reaction in a Wassermann test of the spinal fluid were misleading in this case, and only a recheck of the serological test and the progressive course demanded consideration of another diagnosis. The electroencephalogram suggested a single lesion and localized it. The presence of a tumor was established by ventricular studies.

CASE 2: An 83-year-old woman was admitted to the hospital with left hemiparesis of short duration. The history and results of examinations were consistent with a right-sided subdural hematoma. The patient promptly improved, however, and was dismissed without operation. An electroencephalogram at the time was normal. Two months later the patient reentered the hospital with a well-defined left homonymous hemianopia and left hemiparesis. She was believed to have thrombosis of the right middle cerebral artery, although subdural hematoma, or a space-occupying lesion were not considered to be excluded. An electroencephalogram now showed a right parieto-frontotemporal dysrhythmia. Angiography further suggested an expanding mass lesion in the frontoparietal area. The patient's condition became so critical following angiography that ventriculography was considered too hazardous. The patient died soon thereafter. At autopsy, isolated gliomas (glioblastomas multiforme) were observed in both hemispheres.*

Comment: In retrospect, it now seems clear that subdural hematoma should have been excluded at the outset by direct visualization. The normal electroencephalogram then would not have been so impressive, and air studies or an angiogram would have been the logical procedure. The unwillingness of the family to have any major procedures done in view of the advanced age of the patient is scant comfort for the failure in diagnosis.

*A son of this patient, also studied at the Institute, had a right acoustic neurofibroma.

CASE 3: A 31-year-old housewife complained of auditory hallucinations and left-sided sensory seizures for a period of ten months. No abnormalities that might account for the symptoms were observed upon examination. The cause was considered to be either a vascular anomaly or a tumor in the right temporoparietal region. A normal electroencephalogram and twice-confirmed (angiography) occlusion by thrombosis of the right carotid artery only increased the suspicion of a vascular disturbance of the right cerebral hemisphere. The patient did not improve on a medical regimen during the following year. In another electroencephalogram there was phase reversal in the right temporal leads. A ventriculogram suggested an expanding lesion in the parietal region. At operation an astrocytoma of the right temporal lobe was resected.

Comment: A normal electroencephalogram does not necessarily exclude the presence of an intracranial tumor. In this case the discovery by angiography of a thrombosed internal carotid artery was also misleading, suggesting a vascular condition. The factor which led to the discovery of a tumor was the progressive clinical course and a second electroencephalogram.

CASE 4: The patient was a man 55 years of age. The rather sudden onset, five weeks previous to admission, of left hemiplegia, with temporary improvement, suggested an occlusion of the right middle cerebral artery. Normal blood pressure and the absence of papilledema further implied such a lesion. Fronto-occipital headaches and mild mental dullness were the only signs that indicated a possible increase in intracranial pressure. An electroencephalogram showed delta waves and phase reversal in the right frontal leads. A ventriculogram disclosed a mass lesion in the right parietal lobe. At operation a metastatic lesion in the postparietal lobe was resected. Although extensive search was made the primary site was not found.

Comment: In this case the electroencephalogram showed correct lateralization, but of course did not show the precise nature of the lesion. Only ventricular studies were useful in demonstrating the true expanding nature of the lesion.

CASE 5: A 62-year-old man was thought to have a thrombosis of the left middle cerebral artery because of apraxia and weakness on the right side of somewhat slow evolution. There were no symptoms or signs of increased intracranial pressure. An electroencephalogram showed dysrhythmia of the entire left side. Air studies indicated a shift of the ventricular pattern toward the right with downward displacement of the lateral ventricle. Glioblastoma multiforme of the left frontal lobe was observed in a biopsy specimen.

Comment: In this case the patient, suspected of having an occlusive vascular lesion, did not improve on a medical program. An electroencephalogram lateralized the lesion correctly but did not show its precise location. Again a ventriculogram was necessary to disclose the true nature of the lesion.

CASE 6: A 64-year-old Italian male had a history of progressive left hemiparesis and convulsions, limited to the left side of the face, for two months. He had been stuporous for ten days. On admission the patient was acutely ill. The blood pressure was 140 mm. of mercury systolic and 86 mm. diastolic, and the pulse rate 120 per minute. The temperature was 101.4° F. Papilledema and other signs of pressure were absent. The electroencephalogram showed phase reversal activity in the left parieto-occipital leads. In ventriculogram a shift to the left, without distortion, was observed. At opera-

tion, a glioma (ganglioglioma) was found deep in the right temporal lobe.

Comment: The normal blood pressure, the absence of signs of increased intracranial pressure, the completeness of the hemiparesis, together with the appearance of acute illness, the elevated temperature, and the loss of consciousness suggested an extensive softening of the right hemisphere incident to vascular occlusion. On the other hand, the left-sided facial seizures, which temporarily aggravated the progressive left hemiplegia over a two-month period, were more suggestive of intracranial tumor. The electroencephalogram, moreover, was confusing because dysrhythmia was contralateral.

CASE 7: For 18 months a 31-year-old housewife had had sharp throbbing pains, extending from the right arm to the right ear, together with right hemiparesis. Convulsive movements of the right thigh were also occasionally experienced. The blood pressure was 110 mm. of mercury systolic and 80 mm. diastolic. There was no papilledema or sensory impairment. When the patient did not improve in six weeks on a medical program, she was admitted to the hospital. An electroencephalogram showed a minor left temporal dysrhythmia. In spite of suggestive obstruction of the left internal carotid artery, the angiogram showed some abnormal vessels in the left parietal region. The patient suddenly died on the second hospital day. A cystic astrocytoma of the left parietal lobe was observed at autopsy.

Comment: Although it was believed at the time of the first examination that a tumor of the left frontal lobe could not be entirely excluded, the first impression was that the symptoms were caused by hemorrhage, perhaps from a vascular anomaly in the region of the left thalamus. In retrospect, it seems logical that the patient's age, the duration of the symptoms, and the convulsive jerking of the right hip should have suggested further investigation at the time she was first observed. When finally the patient was hospitalized the electroencephalogram correctly lateralized the lesion while the angiogram precisely localized it.

CASE 8: A 66-year-old Caucasian woman had left hemonymous hemianopia and left spastic hemiplegia of three weeks' duration. The blood pressure was 120 mm. of mercury systolic and 70 mm. diastolic. There was no papilledema or other sign of increased intracranial pressure. An electroencephalogram showed a definite right-sided dysrhythmia. In a ventriculogram a right temporoparietal expanding lesion was observed. At operation a cystic glioma (glioblastoma multiforme) was verified and a nodule was removed from the wall of the cyst.

Comment: The age of the patient and the neurological findings suggested an extensive softening due to vascular occlusion of the right cerebral hemisphere. This was especially indicated in the absence of any signs of increased intracranial pressure. The clinical course was a little too long (three weeks) for the ordinary occlusive lesion, and it was concluded that an intracranial expanding lesion was to be considered. To further confuse the picture, the history of a fall five months earlier suggested the possibility of subdural hematoma or hygroma. An electroencephalogram and a ventriculogram established the diagnosis.

GENERAL CONSIDERATIONS

Of the eight patients reported upon, four were below 55 and four above 62 years of age. In the younger age group two patients were 31 and one was 45 years of age. This fact suggests that the problem of differentiating cerebral vascular lesions from tumors may arise in younger persons and not only in the older age group as frequently has been stated.

The types of vascular lesions simulated in these cases were meningovascular syphilis, subdural hematoma, carotid artery thrombosis with impaired cerebral circulation, hemorrhage into the thalamus, and thrombosis of the middle cerebral artery or its branches. In seven cases the tumors provoking the symptoms were gliomas—ganglioglioma in two cases, astrocytoma in two, and glioblastoma multiforme in three cases (in one of which the growths were multiple, primary tumors). In the eighth case the lesion was metastatic tumor, the primary site of which could not be found.

Only in two cases (Cases 6 and 7) did focal seizures suggest the presence of neoplasm. In one other case (Case 4) occipitofrontal headaches along with mental obtuseness suggested a tumor. The "piecemeal" hemiplegia described in the literature was illustrated in Case 7.

In only three of the five cases in which tumor was considered initially in differential diagnosis was there lateralizing disturbance of the electroencephalogram wave pattern. However, in all eight cases the lesions were ultimately lateralized or localized by electroencephalogram tracings. It appears certain that electroencephalography, when correctly interpreted, may be depended upon to serve as one of the instrumental factors in differentiating tumors from atypical vascular phenomena.

In two of the cases the demonstration of thrombosis of the carotid arteries by angiogram was misleading, suggesting that an impairment of the circulation of the lateral cerebral hemisphere was the cause of the symptoms.

Papilledema and increased cerebrospinal fluid pressure were conspicuously absent throughout the course in all the patients, although one of them was observed for 18 months and another for ten months.

In six of the eight cases, final and conclusive proof of the nature and location of the causative lesion was given by ventriculogram.

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Studies of the "Antihistaminic" Effect of Pyribenzamine Administered by Various Routes

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SUMMARY

Utilizing histamine electrophoresis, the degree and duration of "antihistaminic" effect of varying doses of Pyribenzamine® administered by different routes were studied.

Delayed action Pyribenzamine in 50 mg. and 100 mg. dosage exerted a small but measurable anti-wheaing effect five hours after ingestion. The larger dose exerted approximately twice the effect of the smaller. The anti-wheaing activity lasted five to six hours.

Pyribenzamine given intravenously affected the wheaing response one hour after administration. A peak of activity was reached two to two and a half hours after injection, and "antihistaminic" effect continued for a total of five hours.

The inunction of 250 mg. and 500 mg. of Pyribenzamine in an ointment base resulted in sufficient absorption of the drug to produce a measurable anti-wheaing effect. The "antihistaminic" activity was noted three hours after application and lasted 10 to 12 hours from the time of inunction.

SINCE the introduction of the first "antihistaminic" compound by Fourneau and Bovet in 1933 an almost limitless number of related and similarly acting compounds have become available. A variety of methods of administration, including oral, intravenous, inhalation, and topical routes, have been used. Despite the widespread use of these drugs and their administration by various methods, little is known about the exact manner in which they function in man. The time interval between administration and therapeutic effect, the duration of activity, the degree of "antihistaminic" action in relation to dosage, and the influence of method of administration, have not been completely studied in human beings. To obtain further data concerning these factors, the present study was undertaken.

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MATERIALS AND METHODS

Pyribenzamine® was administered to groups of ten subjects each in varying dosage by several routes. The "antihistaminic" effect in each instance was measured by histamine electrophoresis, a method described in detail by Cohen and Friedman.[1] Sternberg, Perry and LeVan[3] used this technique with modifications to determine the comparative "antihistaminic" activity of 13 commercially available "antihistaminic" drugs administered orally. Briefly, the method utilizes a 2-milliampere current for two minutes to introduce serial dilutions of histamine base into the skin of the flexor surface of the forearm. That dilution which produces diffuse wheaing at the site of the positive electrode is considered to be the initial threshold dilution. This is not an actual quantitative determination of the amount of histamine base entering the skin but represents the concentration of histamine base per cubic centimeter of solution necessary to produce a wheaing reaction. The "antihistamine" to be tested is then given and wheaing threshold determinations made at varying intervals depending upon the route of administration of the drug. "Antihistaminic" activity is manifested by a raising of the threshold—that is, a more concentrated solution is necessary to produce diffuse wheaing. The difference in micrograms of histamine base per cubic centimeter of solution between the initial threshold concentration and the subsequent threshold concentrations represents the amount of histamine base "blocked" by the "antihistaminic" drug administered.

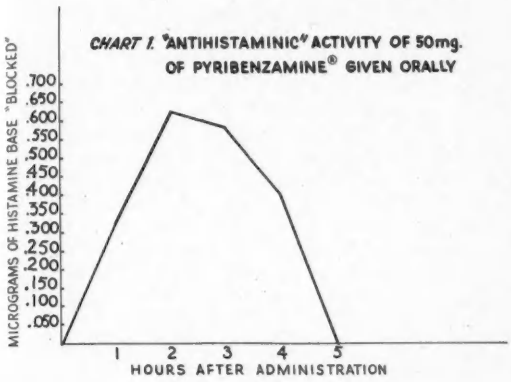
Using this method, Perry and Hearin[2] determined the degree and duration of the "antihistaminic" activity of 50 mg. of orally administered Pyribenzamine. The results of that study are shown in Chart 1.

It will be noted that the "antihistaminic" activity of Pyribenzamine orally administered reaches a maximum of 0.63 micrograms of histamine base "blocked" two hours after ingestion. This activity is maintained for another hour and decreases by the fourth hour; in five hours no effect can be measured.

RESULTS

Histamine electrophoresis, as described, was used to measure "antihistaminic" activity in the following studies:

1. Orally administered enteric coated (delayed-action) tablets of Pyribenzamine in 50 and 100 mg. doses were given to two groups of ten subjects each.



Whealing thresholds were determined at hourly intervals for periods ranging up to 12 hours.

2. Pyribenzamine was injected intravenously in 1 cc. and 2 cc. doses into 20 subjects, ten subjects receiving 25 mg. and ten subjects 50 mg. of the drug. Threshold determinations were done at half-hour intervals.

3. Cutaneous absorption of Pyribenzamine was studied by the inunction of 5 gm. and 10 gm. of a 5 per cent Pyribenzamine ointment* containing 250 mg. and 500 mg. of Pyribenzamine respectively. The ointment was applied to the inner aspects of the thighs of twenty subjects, ten in each group. Whealing thresholds were determined hourly up to 12 hours.

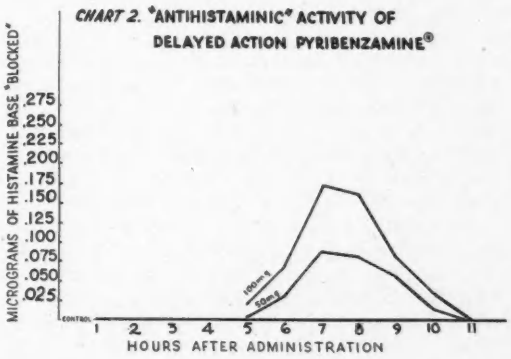
The difference between the initial and subsequent whealing threshold reactions, expressed in micrograms of histamine base per cubic centimeter of solution, were averaged for each of the groups studied. Placebo controls were given to groups of ten subjects each by the routes of administration used in this experiment. The subjects were males, white and negro, between 20 and 49 years of age. They received no oral medication for 24 hours before testing.

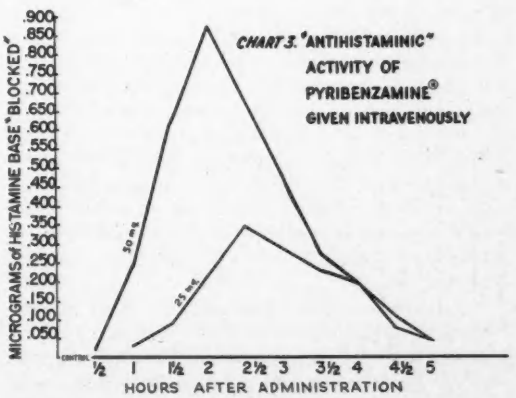
The results obtained by the oral administration of 50 and 100 mg. of delayed action Pyribenzamine are shown in Chart 2. A latent period of about five hours followed the ingestion of the drug. In six hours "antihistaminic" effect was manifested and reached a peak seven hours after the compound was taken. This maximum effect was 0.085 micrograms of histamine base "blocked" by administration of 50 mg. and 0.175 micrograms "blocked" by 100 mg. of delayed action Pyribenzamine. "Antihistaminic" activity was manifested up to ten hours after administration of the drug and for a period of five hours from the time its activity could first be measured by the method used. It will be noted in the chart that considerably more "antihistaminic" effect was obtained when a larger dose was given, but in both instances the form of the curve and the time relationships were identical. In control subjects receiving an oral placebo there was no change in the whealing threshold during a similar time period.

The "antihistaminic" effect obtained by the intravenous injection of 25 mg. and 50 mg. of Pyribenzamine is shown in Chart 3. A preparation of normal saline solution containing 25 mg. of Pyribenzamine per cubic centimeter was used. Thresholds were determined at one-half hour intervals. It will be noted that little measurable "antihistaminic" effect was present one-half hour after administration of 50 mg. of Pyribenzamine. The peaks of "antihistaminic" activity—0.88 and 0.35 micrograms of histamine base per cubic centimeter "blocked" by 50 mg. and 25 mg. of Pyribenzamine, respectively—were reached in two to two and a half hours. The 50 mg. dose resulted in considerably more "antihistaminic" activity than did the 25 mg. dose, although the duration of activity was the same, approximately five hours.

The ten control subjects, given 2 cc. of normal saline solution by injection, had no change in whealing threshold during a similar period.

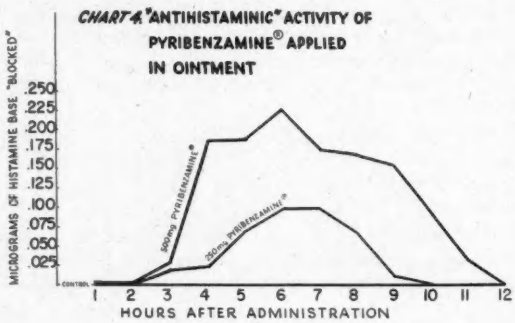
One group of ten subjects was given 250 mg. of Pyribenzamine in a 5 per cent ointment by inunction and another group of ten was given 500 mg. by the same route. The ointment was thoroughly rubbed





*The ointment base consisted of cholesterol, stearyl alcohol, lanolin anhydrous, white petrolatum and white wax.

into the inner aspect of the thighs for a five-minute period. Threshold determinations were done at hourly intervals. A latent period of about three hours was evident (Chart 4) followed by a measurable "antihistaminic" effect. The peaks of activity —0.100 and 0.225 micrograms of histamine per cubic centimeter "blocked" by 250 and 500 mg. of Pyribenzamine, respectively—were reached six hours from the time of inunction. "Antihistaminic" activity was measurable up until nine hours following the application of 250 mg. of Pyribenzamine and eleven hours after the application of 500 mg. Ten subjects treated with the ointment base alone had no change in the whealing thresholds.



DISCUSSION

The "antihistaminic" effect of 50 mg. and 100 mg. of "delayed action" Pyribenzamine tablets as measured by histamine electrophoresis is less than that of the more rapidly absorbed 50 mg. tablet. In a previous study the authors demonstrated a peak of "antihistaminic" activity—0.7 micrograms of histamine base "blocked"—two hours following the oral ingestion of the more rapidly acting 50 mg. tablet. As shown in Chart 2, delayed action Pyribenzamine in 50 mg. dosage exerted an "antihistaminic" effect of 0.085 micrograms of histamine base "blocked" while 100 mg. resulted in a "blocking" effect of 0.175 micrograms. The peak of "antihistaminic" activity of delayed action Pyribenzamine was reached seven hours after ingestion of the drug. Previous studies of the disintegration time of the enteric coated tablets used in this experiment indicate that the release of Pyribenzamine begins approximately five hours after ingestion. However, the coating has been designed to perforate slowly rather than to completely disintegrate within a short period of time. Hence only small amounts of Pyribenzamine are released at any given time. It appears likely that a greater degree of "antihistaminic" effect would be measurable if the enteric coating were to disintegrate rapidly after an initial four- to five-hour delay.

As shown in Chart 3, the intravenous administration of 50 mg. of Pyribenzamine resulted in a pronounced degree of "antihistaminic" activity. A peak of 0.88 micrograms was reached two hours after injection, as compared to a peak of 0.7 micrograms two hours after the oral administration of the 50 mg. rapidly acting tablet. Intravenous injection of 25 mg. resulted in a peak of activity of 0.345 micrograms of histamine base "blocked." A latent period of one-half hour to one hour followed the injection of the drug irrespective of dosage. This suggests the possibility that Pyribenzamine must first undergo a metabolic change before it causes anti-whealing activity. Further clarification of this phenomenon is desirable. The five-hour duration of activity observed with orally ingested Pyribenzamine was likewise present following intravenous administration.

All of the persons receiving intravenous Pyribenzamine noted subjective effects in varying degree. These included vertigo, drowsiness, a sense of relaxation, nausea, and consciousness of respiration. Subjective effects were noted with both 25 mg. and 50 mg. doses of Pyribenzamine and appeared shortly after administration of the drug. Rapid injection produced more pronounced symptoms than did slow introduction of the Pyribenzamine. The symptoms persisted for periods ranging between 45 minutes and four hours. One of the most frequently observed effects was the complete relaxation experienced by many of the subjects. Several subjects remarked upon a sense of well-being with complete loss of nervous tension. This effect, if obtained consistently, might prove desirable in clinical syndromes of allergic disease characterized by apprehension and nervous tension. There were no local reactions observed at the sites of injection.

As shown in Chart 4, the inunction of 10 gm. of an ointment containing 500 mg. of Pyribenzamine into the thighs of ten subjects produced a measurable anti-whealing effect three hours after application. A peak of "antihistaminic" activity expressed as 0.23 micrograms of base "blocked" was reached six hours after inunction. Anti-whealing effect was measurable up to eleven hours after the ointment was applied. A similar response of lesser degree was obtained with 250 mg. of Pyribenzamine in 5 gm. of ointment. A peak of "antihistaminic" activity —expressed as 0.1 micrograms of histamine base "blocked"—was likewise reached six hours after the application. Anti-whealing effect was measurable up to eight hours following inunction. Several subjects complained of drowsiness, but it was difficult to determine whether or not this was due to the Pyribenzamine. Acute dermatitis developed in one instance three hours after the application of 10 gm. of 5 per cent ointment. The subject in whom this occurred was withdrawn from the test group.

From the foregoing it is evident that significant amounts of Pyribenzamine are absorbed through the skin. The use of Pyribenzamine ointment over large areas of the body may be expected to produce drowsiness, vertigo, and other side effects of Pyribenzamine. Sternberg and Taylor,[4] among others, have demonstrated the ability of topically applied Pyribenzamine to filter out ultra violet radiation. However, use of the drug in a prophylactic sunburn

lotion or cream is deemed inadvisable because of the significant degree of cutaneous absorption as well as possible sensitization to the drug.

The authors wish to emphasize that the electrophoretic method of measuring "antihistaminic" effect utilizes the whealing reaction. It is believed that the amount of histamine necessary to produce whealing is greater than the minimal amount of histamine capable of producing other allergic phenomena. Hence, satisfactory therapeutic effects may be obtained at "antihistaminic" levels well below the peaks of activity demonstrated in this study. Further, other reported actions of "antihistaminic" drugs, such as anti-acetylcholine, sympathomimetic or sympatholytic effects not studied in this experiment, may play a therapeutic role in allergic syndromes.

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Discussion by MOLLEURUS COUPERUS, M.D., *Los Angeles*

I have enjoyed this paper very much. The authors have emphasized again the need for a dependable quantitative method by which we can measure the antihistaminic activity of various compounds. It is evident from the results of many workers that the experimental antihistaminic activity of the various drugs now available is not necessarily a dependable guide to the therapeutic value of such drugs in clinical medicine; those giving experimentally the best results may not rank that high when subjected to clinical evaluation. Even the degree of effectiveness in preventing whealing from histamine cannot be translated directly into a comparable effectiveness in the treatment of urticaria. In spite of this limitation, the methods at present available for the study of antihistaminic activity have been of inestimable value, and with continued work such as has been reported in this paper more reliable results will be obtained.

Doctors LeVan, Sternberg and Perry have employed iontophoresis to introduce histamine into the skin, which has also been used by a number of other workers with satisfaction. In evaluating the results reported in this paper, we must remember that the rate and degree of absorption from the gastrointestinal tract of the orally administered antihistaminic are subject to marked variation, and only a large series would give us reliable results when using this route. The inunction method would be subject to similar variation in transepidermal absorption. These variable factors might be avoided perhaps to a large degree by injecting the histamine and its antagonists simultaneously into the skin, using a sufficient number of control injections of each in each individual. Nilzen employed this method with great satisfaction, using 0.05 cc. of the combined material intradermally. One might also introduce both the histamine and the antihistaminic by iontophoresis if one wants to avoid injection technique.

The "Slipped Elbow" of Young Children

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SUMMARY

"Slipped elbow" is essentially a distal subluxation of the head of the radius, caused by traction in the forearm, occurring in young children. It is easily reduced by the manipulation described. Although spontaneous reduction may occur during sleep, neglect may result in deformity of the elbow.

"SLIPPED ELBOW" is a fairly frequent traumatic condition which is apparently not generally recognized or diagnosed. It has been called by various names, including "Malgaigne's luxation," "dislocation of the radius by elongation," "the subluxation of young children," or "the painful pronation of young children." The features of this injury have been well described in the literature, running as far back as 1671 (Fournier), but the more recent orthopedic texts make little or no reference to it.

The patient is usually a child under three years of age, although cases have been described in patients as old as six years. Usually the cause of injury is that the child was either lifted by one wrist or, while walking with his hand in that of an adult, stumbled and was supported by the adult, pulling on the arm. Following such an incident the child usually cries out in pain and refuses to use the arm, which may hang motionless by the side or be held supported with the elbow slightly flexed across the front of the abdomen with the forearm in pronation. With the exception of supination, which is resisted by the child, all passive motions of the elbow joint affected appear to be painless. An interesting aspect of the injury is that almost invariably the person who takes the child to a physician thinks that the injury is in the shoulder rather than in the elbow.

The mechanism of the injury appears to be that of subluxation of the head of the radius, which is drawn distally and anteriorly, the anterior edge of the radial head engaging below the lower border of the annular ligament. It is believed also that the posterior portion of the capsule is forced in by atmospheric pressure and becomes pinched between the head of the radius and the capitellum.

Because this condition occurs most frequently between the ages of one and three years and almost never at a greater age than six years, it appears reasonable to assume that the joint structures in children of the ages mentioned are sufficiently lax to permit of the subluxation and that this laxity diminishes as the joint tissues mature. It appears likely that in many instances such luxations reduce spontaneously in the relaxation of sleep.[2] The author is inclined to believe, however, that in some cases the luxation does not reduce without manipulation and that the end result may be a deformity of the elbow (Figure 4). Blodgett[1] reported two cases of "congenital luxation of the head of the radius" which appear to fall in this classification. In both cases the head of the radius was in anterior position and there was deformity. Blodgett analyzed and discussed reports in the literature of 51 similar cases. It appears evident, therefore, that the consequences of this ordinarily simple condition may occasionally be serious. The earlier literature on the mechanism of this injury was well summarized by Stimson[3] in a volume published in 1907, from which the accompanying anatomical figure is reproduced (Figure 1).

TREATMENT

Upon gentle supination of the forearm, usually assisted by flexion at the elbow, there is an audible click, following which the child is able to use the elbow without apparent discomfort. In order to reassure the parent, it is usual to put the affected arm in a sling for a few hours; in lieu of the sling, the child's sleeve may be pinned to its clothing for temporary support.

In the outpatient department of South San Francisco Hospital six cases of slipped elbow have been observed in the past four years. Two cases appear to be of particular interest, one because the condition was recurrent and the other because of a rather pronounced elbow deformity which apparently was the late result of an unreduced dislocation of this character.

Subluxation of the head of the radius. (PINGAUD.)

Figure 1.—Anatomy of "slipped elbow."

From the Department of Surgery, South San Francisco Hospital.

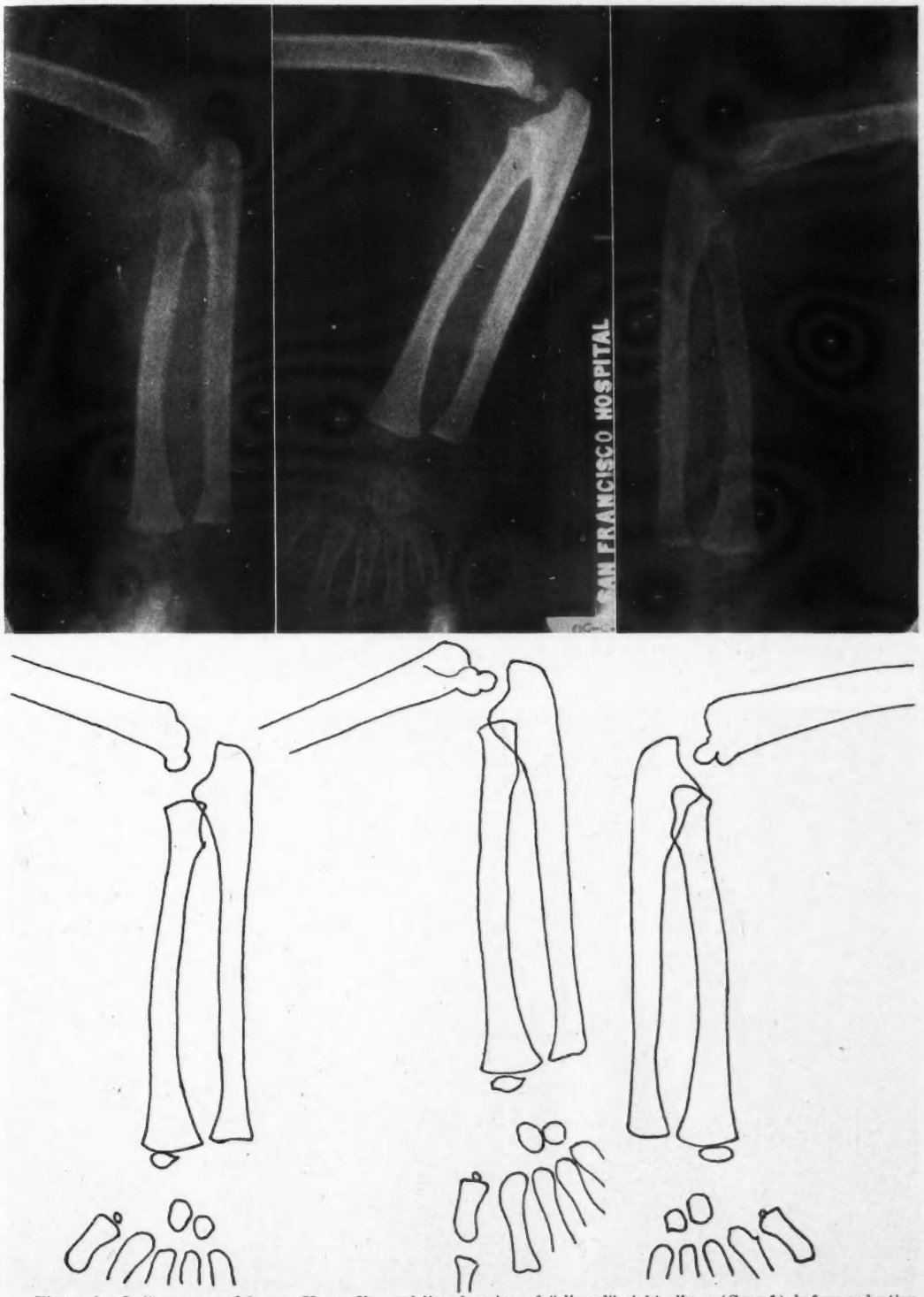

Figure 2.—*Left, upper and lower:* X-ray film and line drawing of "slipped" right elbow (Case 1) before reduction. *Center, upper and lower:* Same elbow after reduction. *Right, upper and lower:* Normal left elbow of same patient for purposes of comparison.

CASE REPORTS

CASE 1: The patient, a girl three years of age, was said to have hurt her right arm while playing with her father. She had been riding on her father's back, and her right arm was pulled around his neck to keep her from falling. When first observed the patient was supporting her right arm with her left hand, the right forearm being in flexion and held across the front of the body in pronation. All passive movements of the elbow were painless, with the exception of supination, which was resisted. The usual gentle flexion and supination gave immediate reduction, with an audible click and complete relief of disability. According to the history given by the mother, the patient had had three similar incidents at the age of two and another at the age of two and one-half, making five in all. X-ray films taken elsewhere during the last previous incident had been reported as normal. Comparison of preoperative and postoperative x-ray films (Figure 2) indicated the very slight degree of lateral displacement of the head of the radius on the ulna.

* * *

CASE 2: A "lump" on the left elbow was noted in the course of a physical examination of a boy 13 years of age, but the origin of the condition was not recognized at that time. Two years later when the patient was recalled for specific examination of the deformity there was 20 degrees' loss of extension and 45 degrees' loss of supination in the joint, but no impairment of either flexion or pronation, and the patient made no complaint of pain. In x-ray films (Figure 3) it was noted that the prominence derived from the head of the radius and was due to dislocation rather than to overgrowth, inasmuch as the roentgenographs showed that right and left radii were approximately equal in length. The x-ray films in this case are quite similar to those presented by Blodgett[1] in a report of cases of so-called congenital luxation.

500 Grand Avenue.

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Figure 3.—Deformity of left elbow (Case 2), probably as sequel of unreduced "slipped elbow."

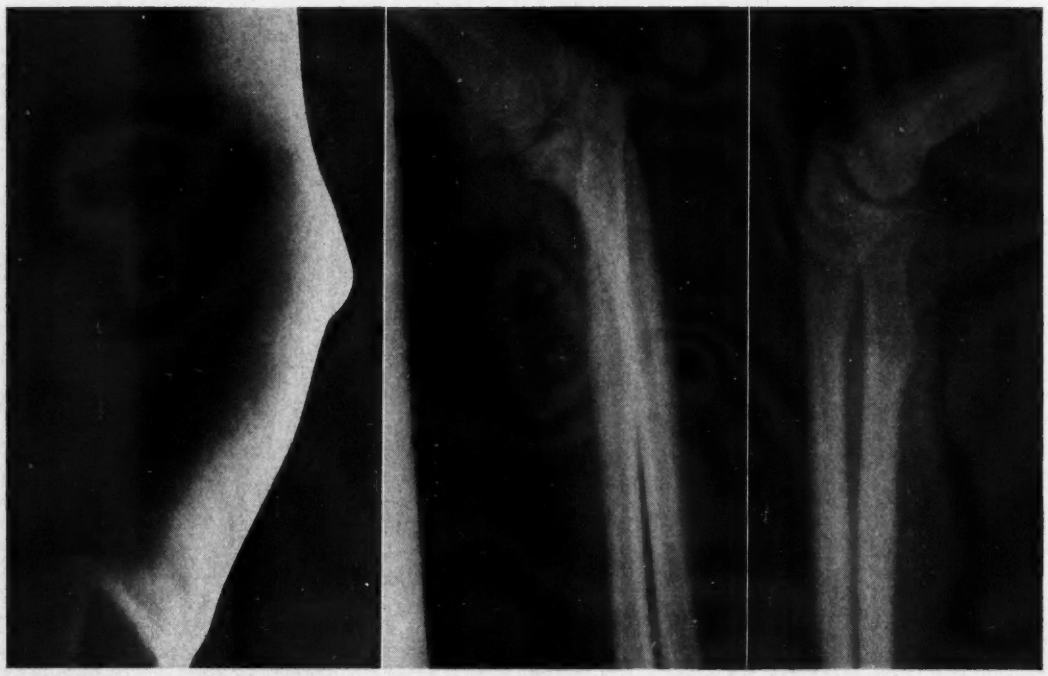

Figure 4.—*Left:* Deformity of elbow (Case 2). *Center:* X-ray film of deformed elbow. *Right:* X-ray film of normal right elbow, same patient.

Pterygia

Etiologic Theories, Methods of Treatment, and Results

R. E. Bartlett, M.D., and C. S. Mumma, M.D., *Los Angeles*

SUMMARY

Although it has been postulated that a pterygium develops from the ordinary pinguecula which is a phenomenon of aging, the average age of patients in a Veterans Administration hospital who were operated upon for removal of pterygia was 34.9 years. Mexicans appeared to be particularly susceptible to the disease. Analysis of the literature and review of observations in the present series of cases indicated that long-continued exposure to the elements, particularly the sun's rays, is a prime etiologic factor and that dust and other irritants are of less importance.

In a study of 285 patients who had pterygia, no correlation of this disease with other local or general disease was observed.

An operation which brings previously unexposed conjunctiva into the area from which a pterygium is removed, and which does not bury the epithelium, was used successfully.

THE majority of patients with pterygia apparently are not thoroughly examined for concomitant disabilities. There are few statistical reports in the American literature.[3, 8, 10, 12, 16] The records of the patients with pterygia at Wadsworth General Hospital, Veterans Administration, Los Angeles, since 1938 have been reviewed. Besides examination of the eyes, complete histories were taken and physical examination was carried out in all cases, in addition to routine laboratory tests, x-rays of the chest and special consultations when indicated.

REVIEW OF THE LITERATURE

A review of the literature regarding pterygia leaves rather an inconsistent and confusing picture. Fuchs[7] in his classic work observed that Bowman's membrane was split and torn by advancing cellular connective tissue. He assumed this was a primary invasion of connective tissue from a pinguecula at the limbus. Schoninger,[15] however, stated that this invasion was secondary to degenerative changes in the cornea just in advance of the invasive connective tissue. Duke-Elder[4] stated that because of the "influence of Fuchs' paper, pterygia were generally classified among conjunctival degenerations, but in the light of the early changes in the cornea, demonstrated biomicroscopically and histopathologically, particularly by Schoninger (1926), it is evident that it should be classed among degenerative diseases of the latter tissue." He stated that "exposure to wind and dust [is an] important predisposing factor," and that, "with rare exceptions [a pterygium], starts over the area of a pinguecula, although it cannot be classed as an extension of the same process." The average age of patients with pterygia operated upon by the authors was 34.9 years, although the pinguecula from which a pterygium usually arises is said to be essentially a change of aging. Duke-Elder,[5] citing a study of 924 persons by Hinnen (1921), noted that pinguecula was not observed in any person less than ten years of age; the condition was present in only 7 per cent of persons less than 20 years of age; the incidence then increased: In persons between the ages of 50 and 60 the incidence was 87 per cent, and in persons over 80 almost 100 per cent.

As a pterygium does not usually occur before the age of 20, apparently the external portion of the conjunctiva must be exposed to the elements for a number of years to cause development of the lesion. A somewhat parallel condition occurs in the skin. According to Becker and Obermayer,[1] "Degenerative senile atrophy occurs in predisposed individuals as a result of long continued repeated exposure to the elements, especially ultraviolet light in sufficient amounts to produce sunburn. The chief change is in the elastic fibers which are thickened and form in severe cases, a thick layer in the superficial dermis, interspersed with collagen fibers."

In "Diseases of the Eye" by Parsons and Duke-Elder,[14] Fuchs is quoted as saying that a pterygium is derived from a pinguecula and prolonged exposure. May[11] mentioned that it usually occurs in elderly persons who are exposed to dust and wind. Dimitry[2] in 1937 found by survey that pterygia were very prevalent in relatively dust-free, humid, non-industrial Louisiana. Fully 40 per cent of patients operated upon were women not exposed to wind and dust. An insignificant number of men patients were working out of doors in the dust bowl. Kamel,[9] reporting from Egypt, stated that a pterygium is both a corneal and a conjunctival disease. The first phase, he said, is limited to the exposed portions of the bulbar conjunctiva, and he called this phase "chronic exposure conjunctivitis." The same process may continue and affect the cornea. This causes growth of connective tissue on the cor-

From the Ophthalmological Service at Wadsworth General Veterans Administration Hospital, Los Angeles 25, California. Published with the permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the authors.

nea next to the limbus which contracts to pull adjacent conjunctiva onto the surface of the cornea. Kamel considered the process an inflammatory reaction to exposure irritation, rather than degeneration.

HISTOPATHOLOGY

Histopathologically, a pinguecula differs in some respects from a pterygium. A pinguecula has very few cells or blood vessels. It is a collection of degenerated connective tissue fibers and embedded masses of hyalin. According to Fuchs,[6] dark, staining fibers formerly believed to be degenerative elastic fibers are actually degenerated connective tissue fibers which have undergone a chemical change altering the staining properties.

A pterygium contains a moderate number of round cells and blood vessels. Loose connective tissue advances onto the cornea at the level of Bowman's membrane to cause fragmentation of the membrane. The connective tissue at the neck of the lesion is denser, more homogeneous and more closely resembles the structure of a pinguecula. Conjunctival epithelium covers the growth as if it were pulled onto the cornea by contraction of the fibrous connective tissue. Traction is evidenced by the longitudinally parallel fibers, and retraction may be observed after the head of the lesion is cut free from the cornea. Further evidence of retraction is the reduction in the amount of astigmatism that sometimes occurs.

In biomicroscopic examination of the head of a pterygium, fine pinpoint opacities may be observed at the level of Bowman's membrane, a variable distance in advance of the growth. The first changes are said to occur at the points where nerve fibers pierce the membrane. A small homogeneous mass filling the mouth of the nerve canal can be seen by high power on the microscope. There are a few wandering cells in the vicinity. Further toward the limbus, Bowman's membrane can be seen splitting and unravelling. The progress of the growth of a pterygium can be estimated by noting the vascularity and by the width of the rim of opacities in advance of it.

PRESENT STUDY

Since 1938, 140 patients have been operated upon at Wadsworth General Veterans Administration Hospital for either single or bilateral pterygia. A total of 175 operations were performed. These were done by different members of the staff and by various methods. In 119 cases the McReynolds method was used, and in 44 a modification of Desmarre's method. Excision was carried out in nine cases, and in three cases mucous membrane grafted from the lips was transplanted. In addition, pterygia were observed in 145 cases in the course of routine examination of patients who, either through choice or because of contraindication, were not operated upon. Of the 140 patients operated upon, 25 had recurrent pterygia (23 of them had had previous operations in which the McReynolds or a procedure of similar type was used). Of the group with recurrence, 12 were Mexicans. Of the 115 patients without recurrences 13 were Mexicans, four were Negroes, two Orientals and an Indian. In the group of 145 not operated upon there were 21 Mexicans, nine Negroes and four Orientals. More than 50 per cent of the total number of patients were occupied in outdoor labor, with exposure to wind, dust and sun, 20 per cent of the patients with recurrent pterygia were farmers and 18 per cent were truck drivers.

NO CORRELATION WITH OTHER DISEASES

The records were carefully reviewed to determine if there was any relationship between the presence of pterygia and vasomotor rhinitis, sinusitis or allergic disease; whether there was increased instance of conjunctivitis, blepharitis or tear sac invasion; and whether there might be concomitant metabolic abnormality or skin disease. No such correlations were found, even in cases in which there were from two to eight recurrences.

Of the 25 patients with recurrent pterygia, 12 had no history of previous significant illnesses. Two of the remaining 13 had malaria, and the following conditions occurred in one instance each: gallbladder disease, glycosuria, chronic colitis, chronic arthritis, hives, asthma, bronchitis, chronic teniasis, arrested tuberculosis, syphilis inadequately treated, cystitis, and acute bursitis.

In nine of the recurrent cases, the pterygia were bilateral. Sixteen patients had a single recurrence; five had two recurrences; two had four; one had five and one had eight. More than 50 per cent of the patients noticed recurrence within three months after operation. In approximately 25 per cent of the remaining cases, recurrences occurred as late as three to fifteen years after operation.

COMPLICATIONS

There were a few complications encountered. Oral mucous membrane was transplanted in one case in which there were five recurrences and symblepharon. At the time the patient was discharged from the hospital, the visual acuity was 20/200 and there were five prism diopters of left hyperphoria. In an additional case, corneal peeling was carried out to completely remove a 3 mm. pterygium. The visual acuity was 20/20 when the patient was discharged one week after the operation. At a follow-up examination two and one-half months later, recurrence of the pterygium was noted, and the vision was 20/20 with minus 1.25 sphere combined with plus 3.50 cylinder, axis 110. The growth was resected, following which the refraction showed minus 1.75 sphere combined with plus 3.50 cylinder, axis 97 for 20/20 minus 2. In one case in which a skin graft was excised from a patient who had had eight previous operations for recurrences, the vision was reduced to 20/70 with a high astigmatic correction.

In another case, in which the patient had a pterygium extending into the pupillary area, refraction prior to operation was O.D. plus 3.50 sphere combined with minus 2.25 cylinder, axis 5, 20/20 minus

1. Postoperatively, in ten days, the correction was O.D. plus 4.00 sphere combined with minus 2.25 cylinder, axis 5, 20/80.

SURGICAL PROCEDURES

As with etiology, the literature regarding the surgical treatment of pterygia is confusing and paradoxical. Some investigators would excise the growth. Others would transplant it, upon the fallacious rationale that they are redirecting it so that further growth will be harmless. Transplantation may be beneath the conjunctiva into a pocket, as in the McReynolds[12] method. If there is an objection to burying the mucous membrane, transplantation may be into an opening on the surface of the conjunctiva. Another method is to cauterize the underside of the growth with carbolic acid and let it fall back toward the caruncle without suturing.

Some ophthalmologists do a superficial peeling of the cornea to remove the pterygium. Others remove it in the line of cleavage and curette the remaining tags. Many stress removing the gray, translucent area in advance of the head of the growth. Much attention is given to the disposition of the main body of the pterygium, which is conjunctival. Other investigators recommend scraping connective tissue away from the sclera for several millimeters from the limbus and allowing this area to fill slowly with epithelium.

The general consensus is that a pterygium is a corneal disease, and that the growth progresses only into an area previously showing a gray infiltrative rim. Operation based on this concept would aim at removing all of the pterygium from the cornea. It would appear to make little difference whether the body of the pterygium, extending back to the caruncle, is excised, transplanted, cauterized, or given x-ray treatments; because in any case, conjunctiva with blood vessels and connective tissue would soon be found at the limbus to furnish cells for further growth if the "corneal diseased" area still existed. (Normal conjunctiva brought up to the limbus to cover the denuded area is not nearly as liable to grow over the cornea.)

ADVANTAGES OF MODIFIED DESMARRE'S OPERATION

In practice, it would seem best to consider a pterygium both a conjunctival and a corneal disease. The authors have been impressed by the results obtained with a modified Desmarre's operation. (A similar modification was reported by Miller[13] in 1937.) Forty-four operations were done by this procedure. The pterygium was removed from the cornea by doing a very superficial peeling of the cornea, using a number 15 Bard-Parker blade. Connective tissue was scraped from the sclera at the limbus for a distance of 2 mm. The conjunctiva was undermined in all directions (Figure 1). Two parallel incisions above and below the pterygium were extended back toward the caruncle for 3 to 4 mm. An oblique incision of 3 mm. through the conjunctiva was made to extend from below the pterygium down toward the inferior cul-de-sac. The pterygium was sutured into this gap. The conjunctiva was cut at the limbus for a distance of 2 mm. above and below the gap left by the pterygium. The conjunctiva was thus mobilized and approximated. When sutured it usually extended over the cornea a short distance. It receded back to the limbus as healing progressed. The advantages of this operation can be enumerated:

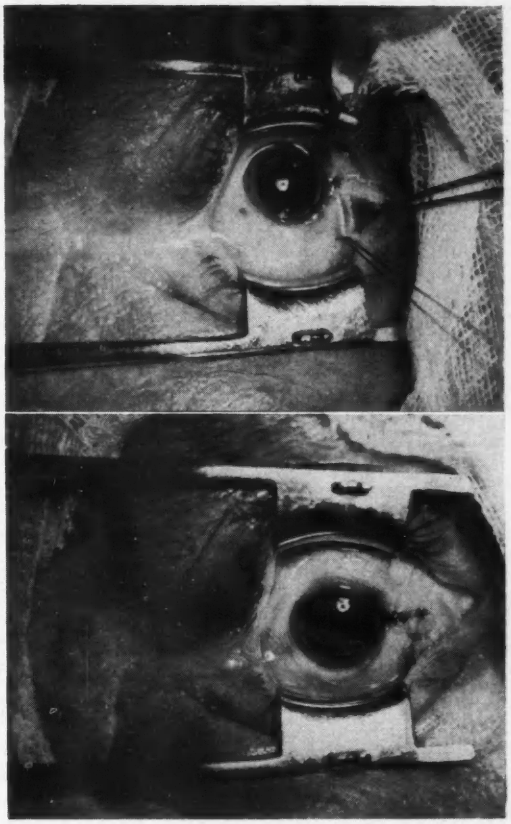

Figure 1.—*Upper picture:* Conjunctiva undermined and advanced over site of pterygium which has been raised from its bed to be transplanted at lower edge of incision. *Lower picture:* Operation completed.

1. Mucous membrane is not buried as it is in the McReynolds operation. (While little irritation seems to result from the McReynolds operation, nevertheless burying epithelium is not a sound surgical principle. Moreover, the double thickness remains rough for some time, and small cysts may form.)

2. It is felt that less vascularization of the postoperative scar occurs when it is protected by the conjunctival flap while healing. The flap then recedes to the limbus.

3. A bulbar conjunctiva that has been protected from exposure by the eyelids is used to cover the exposed portion of the globe where the pterygium was removed. In cases in which this operation was used there was only one recurrence.

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Medicine in the Talmud

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THE TALMUD[1, 2] is a commentary on the Bible and also an encyclopedia. It includes portions on jurisprudence, history, ethics, mythology, astronomy, mathematics, philosophy, theology, medicine, anatomy and botany. It was compiled by a number of Jewish scholars. The Talmudic teachings, for centuries transmitted orally, were finally placed in definite literary form at the end of the fifth century as a collective labor of many generations.

Much attention was given in the Talmud to medicine, to study of principles and theories which were later discussed by modern scientists and clinicians. Rabbis of considerable erudition and sagacity evolved a system of treatment and hygiene which in scope and quality stood far above the period of civilization in which they lived.

The Talmud contains no medical treatises as such; medical subjects are discussed in connection with religious rites and ceremonies. As guides to an understanding of stages in the development of medical lore, the Talmudic statements have great historical value. Many old methods applied by the Talmudists were strikingly like those with which medical science is occupied at present. The medical instructions and directions of the Talmud are so positive and so concrete that it is quite evident that the Talmudic physicians were versed in etiology and pathology; their medical knowledge was based not only on hypotheses and traditions, but also on observation, dissection, and experimentation.

The wealth of Talmudic medicine is best revealed when it is compared with the methods of modern medicine, for many of the views, hygienic rules and methods of treatment of the ancient Talmudic physicians stand inspection in the light of today's scientific knowledge.

The diagnosis of diseases was made on the basis of palpation, observation and, sometimes, the application of physical and chemical reagents. Blood tests were made with a number of reagents composed of seven chemicals. The diagnosis of stomatitis was made on the basis of the redness, swelling and tenderness of the inflamed area. In cases in which the diagnosis was doubtful, the patient was isolated for observation. The diagnosis of skin diseases was made on the size, shape, exudation and color of the lesion. Clinical observation took from one to three weeks. The Talmud suggested that a thorough examination was necessary for correct diagnosis. "A physician who treated without examination brought harm." "A physician who heals for nothing is worth nothing."

The Talmud considered that the prognosis of an illness depended upon the cause and the site affected. Internal diseases were more serious than external. The most dangerous were angina pectoris, meningitis, inflammation of the spinal cord, and gallbladder disease. Heart disease was recognized as a grave malady because the function of all organs depended upon the heart. Open wounds were treated as a serious disease; cancer was considered dangerous. Diseases of the eye were also regarded as grave. Perforations of the heart, esophagus, stomach or volvulus were believed to be fatal, as was injury of the spinal cord. Atrophy or abscess of the kidney caused death, but extirpation of the spleen, removal of the uterus and accumulation of transparent fluid in the kidney were not considered fatal.

The Talmud considered hygiene to be of the utmost importance. Cleanliness, bathing, proper food, regular living, isolation of infected patients and prevention of contagious diseases were urgently advised. "Be careful of the flies near the contagious patient." "The amputated organs of the contagious should be buried." Patients with leprosy were isolated. Persons who had been in contact with a leper were isolated during the incubation period.

To drink water which flowed through a filthy place was forbidden because of the danger of contamination. The drinking of dish water was not permissible. Wine or milks left uncovered should not be drunk because of the danger of a hidden snake entering and drinking the liquid and polluting it with venom. It was advised that hands be washed before each meal and lips and mouth washed after meals to prevent diseases of gums and mouth. "Water suspected of containing germs should be boiled before using." "Do not drink from unclean glasses." "If you taste soup, do not return remains to the pot."

To prevent an offensive odor from the mouth, plenty of fresh water to drink and frequent mouth washes were recommended. The food for eating must be prepared fresh and clean. It was recommended one should not live in a town where there were no vegetable gardens. The Talmud also warned against living in a town where there were neither physicians nor bathing facilities.

It was suggested that the food to be eaten should be varied. Carbohydrates and vegetables were regarded as unsatisfactory, but together with fats they were recognized as a source of energy, producing power. "Do not eat immoderately," was an admonition then as now. Other statements seem even today to have been born of studious observation: "Wine in small amounts is a remedy; in large amounts it is poisonous"; and, "The following seven objects are beneficial if used moderately and harmful if used excessively: travel, luxury, work, wine, sleep, warm water, and venesection for medical purposes."

The Babylonian Talmud[1] states that the causes of diseases are uncleanliness, cold wind, improper food, worry, fear, trauma, hereditary weakness, and infections. Unhygienic conditions are considered important factors contributing to sickness. The ancient rabbis found that diseases were prevalent in unclean places; cold and heat were factors in many maladies. Living in damp places and dwelling

where there was insufficient sunshine was observed to be injurious to health; and ingestion of unripened fruits and contaminated water was noted to be dangerous and the cause of many severe diseases. Tapeworms entered the body when beef that had not been boiled thoroughly was eaten. Other observations of etiologic import: More diseases come from overeating than from hunger; lack of exercise results in weakness and nervousness; fright causes palpitation of the heart; trauma of the spinal cord produces limping, while softening of the cord causes tremor of the head; a fall may cause injury to the internal organs with fatal results; hemophilia and epilepsy are hereditary and prevalent only in certain families; the food, utensils and clothing of persons afflicted with contagious diseases are the sources of the spreading of those diseases.

The Talmud speaks of minute organisms and insects as the cause of certain diseases and states that "there are many germs and insects that are dangerous to health; minute organisms existing everywhere in abundance; if man could see them all, he could not exist."

It is remarkable that the Talmudists were the first to state that symptoms of all diseases are merely external manifestations of internal changes in the tissues or organs and that they observed that the nature of the change varied with the disease. At about the same time, the contemporaries of the writers of the Talmud, Hippocrates and his disciples, created a theory that the body contains four humors: blood, phlegm, yellow bile, and black bile. The improper proportion or irregular distribution of these humors caused disease. Later, Galen stated that the normal condition of the body depended upon a proper mixture of the four elements, heat, cold, moisture, and dryness; all symptoms and all diseases were explained on this theory. The ancient medical schools knew very little about pathologic changes. They did not suspect that structural changes appear in the body during disease.

The Talmud established a religious rule forbidding the eating of meat of an animal afflicted with a disease. Therefore, all animals slaughtered were thoroughly examined as to the condition of their internal organs. Thus, much valuable scientific knowledge about diseased structures and morbid processes was made available. The pathological changes of organs with regard to color, position, consistency and cavities were noted. Bones, muscles, glands, and internal organs were carefully described as to histologic and topographic features. The exact number of bones in the human body was determined when Rabbi Ishmael dissected the body of a woman who had been executed as a criminal.

In 1855, Wilcker suggested a method of determining the total quantity of blood in the body. This consisted in washing the blood from the vessels with water and estimating the amount of hemoglobin in the washings. A similar method, by which the color of all the blood in the body mixed with a measured amount of water was compared with samples of blood and water in known rates, was used by the Talmudists some 1,500 years earlier. And they obtained more accurate results than Wilcker. Rabbi Ashi discovered the presence of "elastic threads" in a case of pulmonary disease. The rabbis were able to determine whether bleeding was from the lungs or from other organs by observing the color of the blood.

Hemophilia was first reported by Fordyce in America, in 1784. Hippocrates and Galen made no mention of this disease, and in the medical literature of the Middle Ages there is no reference to it. The Talmudists, however, described the disease 2,000 years ago. In connection with the rite of circumcision there were instances of death traceable to excessive loss of blood. The rabbis characterized such victims as descendants of a bleeder's family. In such instances parents who had lost two sons due to loss of blood were enjoined not to observe this rite for any of their sons born thereafter. The rabbis knew that this disease was transmitted from mother to son, and that women, although not themselves bleeders, transmitted the disease to their sons. The cause of death was explained to be a lack of viscosity of the blood which interfered with the protective property of clotting.

The Talmudists considered that in illness the prognosis depended upon the cause and the site of lesion. They predicted the course and end of certain diseases in accordance with the varying pathological conditions. Blue and light green discolorations of the lung were not considered dangerous; black indicated that the lungs had begun to disintegrate; a bright yellow color was an indication of almost certain death. Softening of the lungs was mortal; an empty cavity was not dangerous to life. In the case of collapsed lungs in an animal, the Talmud gave the following rule: If after the lungs have been immersed in water they can be inflated with air, the flesh of the animal is fit for food; if they cannot be inflated, it is unfit.

The ancient Greek physicians claimed that injury to the trachea or removal of the spleen was fatal. The rabbis stated that a wound in the trachea heals quickly and that removal of the spleen will not cause death. This is in accordance with medical knowledge of today.

Galen supposed that the thoracic cavity was filled with air; he believed that from a physiological point of view such a condition was necessary for the normal process of respiration. The Talmudists, however, stated that such a condition was evidence of a pathological process.

In light of the variety of medical lore and the conflict of theories among the ancients of separate civilizations and cultures, one cannot but conjecture how much fuller and more exact medical knowledge might have become in that day if there had been then the wholesome forums which today stimulate advances in medicine.

350 Post Street.

REFERENCES

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CASE REPORTS

Carbon Tetrachloride Intoxication

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CARBON tetrachloride damages the kidneys and liver in a characteristic manner which is not as well recognized clinically as it might be. The following report of a patient who recovered after drinking carbon tetrachloride demonstrates the resulting disturbances of renal and hepatic function.

CASE REPORT

A 34-year-old white housewife entered the hospital May 14, 1949, with complaint of icterus for 24 hours and emesis for one week.

For five years prior to 1946 the patient had consumed alcohol in "small amounts" with food. In 1946 she began periodically to drink heavily, consuming one pint of whiskey daily at intervals for about one year. In January 1949 she again began to drink heavily and this continued to the present illness. For several days prior to the week preceding hospitalization she had been drinking large amounts of whiskey. When, seven days before hospitalization, no more whiskey was available in the house, she drank an unspecified amount of household ammonia and 3 ounces of rubbing alcohol.

During the following week she ate almost nothing, vomited often, passed dark to black stools, and had generalized upper abdominal pain. At the end of this week she vomited blood and noted epistaxis. The urinary output had been scant all week but was not carefully observed. When jaundice was noted medical care was sought and the patient was immediately hospitalized.

The past history was essentially unimportant. The husband and two children, ages 6 years and 18 months, were living. Pregnancies had been uneventful. Blood pressure and urinalysis in July 1947 were "normal." Blood pressure at term in January 1948 was 150 mm. of mercury systolic and 90 mm. diastolic, and urine at that time contained a faint trace of albumin. Physicians had often noted an irregularity of the heartbeat but there was no known rheumatic fever and no symptoms indicative of heart or lung disease. Menstrual history was normal with menarche at age of 14. There were no past symptoms referable to the gastrointestinal or genitourinary tracts.

Upon physical examination at the time of admission to the hospital, the patient was noted to be well developed, well nourished, drowsy, and depressed. She was moderately icteric and had fetor oris. No spider angiomata were noted. The respirations were 20 per minute and regular. The pulse rate was 84 per minute and the rhythm was regular. Blood pressure was 134 mm. of mercury systolic and 70 mm. diastolic. The temperature was 98.6° F. Blood was oozing from the nose. Pupillary reactions and extraocular movements were normal, and no abnormality was noted in the ocular fundi. The sclerae were yellow. The tongue was coated and dry, teeth were clean, and the pharynx was not injected. There was no enlargement of lymph nodes. The thyroid gland was not enlarged and there was no venous distention. The neck was supple, and the trachea was in the midline. The lungs were clear to percussion and auscultation, and the breasts were normal. The apparent heart size was not increased and there was a Grade II systolic murmur, loudest at the apex, but heard over the entire precordium. The abdomen was soft and muscles flabby. The liver edge, which was palpable on expiration 3 cm. below the right costal margin in the midclavicular line, disappeared below the sternum in the midline. It was sharp, irregular and tender. Spleen and kidneys were not palpable. No other masses or tenderness were noted. There was no evidence of fluid in the abdomen. No abnormalities were observed in the extremities. Good peripheral pulsation was noted and normal tendon reflexes were elicited. The cervix, corpus uteri and adnexae were normal.

Course in Hospital: At the time of admission to the hospital the diagnosis was alcoholic cirrhosis of the liver with recent exacerbation. The specific gravity of a specimen of voided urine was 1.006, which was significant because of the dehydration. (The correct diagnosis could have been made at this point, but was not.) The reaction was acid and the urine contained 1-plus protein and occasional erythrocytes and leukocytes, but no casts. Vitamin K (72 mg.) was given intravenously and the epistaxis stopped. Because of vomiting, parenteral feeding was necessary on both the first and second hospital days (Chart 1). No electrolytes were given. Urinary output of 700 cc. seemed compatible with dehydration, but because of persistent drowsiness, further chemical studies were ordered.

On the third hospital day (tenth day of illness) the patient was both restless and drowsy, had dark fluid stools and emesis. Demerol® was given for relief of pain. Parenteral feeding again was carried out (Chart 1) and Vitamin K was given. The urine output was 900 cc. and the general picture was still in keeping with the diagnosis of dehydration and severe hepatitis. Later that day, however, the laboratory reports were as shown in Chart 2 (tenth day).

It was then evident that the patient had renal as well as hepatic disease and a search for toxic agents was made. It was known that the patient had ingested household ammonia which is not harmful. The rubbing alcohol which she had consumed contained: ethyl alcohol 70 per cent, acetone approximately 8 per cent, methyl-iso-butylketone approximately 1.5 per cent, and a small amount of sucrose-octa-acetate for bitter taste. None of these agents is known to have such toxic effects.

A partially filled bottle of "Energine Cleaning Fluid, Fireproof" was found in the patient's home and she admitted

From the Cedars of Lebanon Hospital, Los Angeles.

CHART 1.—*Treatment*

	Day of Illness																			
	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Intravenous fluid (cc.)	1,000	2,000	2,000	2,500	2,000	2,000	1,600	1,670	1,550	1,650	....	....	....	....	....	....	....	....	....	....
Sodium chloride (gm.)	0	1.0	1.0	9.5	18	9.0	0	0	1.0	1.0	....	....	....	....	....	....	....	....	....	....
Carbohydrate (gm.)	50	50	50	100	100	50	50	50	....	....	....	....	....	....	....	....	....	....	....	....
Protein (gm.)	0	50	50	25	0	0	0	0	50	50	....	....	....	....	....	....	....	....	....	....
Ringer's lactate (cc.)	0	0	0	1,000	0	1,000	0	0	....	....	....	....	....	....	....	....	....	....	....	....
Vitamin B complex (ampules*)	1	1	1	1	0	1	1	1	....	....	....	....	....	....	....	....	....	....	....	....
Vitamin K intravenously (mg.)	72	0	72	0	72	0	72	0	72	0	72	....	....	....	....	....	....	....	....	....
Vitamin K orally (mg.)	....	....	....	....	....	....	....	....	....	....	30	30	30	30	30	30	30	30	30	30
Blood (cc.)	0	0	0	0	0	1,000	500	500	....	....	....	....	....	....	....	....	....	....	....	....
Liver extract (units)	....	....	....	....	....	....	....	15	15	....	15	....	15	....	15	....	15	....	15	....
Choline (gm.)	....	....	....	....	....	....	....	....	....	....	....	4	4	4	4	4	4	4	4	4

*Each ampule contained: Thiamine hydrochloride, 10 mg.; riboflavin, 10 mg.; ascorbic acid, 100 mg.; pyridoxine hydrochloride, 5 mg.; calcium pantothenate, 50 mg.; nicotinamide, 250 mg.

CHART 2.—*Results of Laboratory Tests*

	Day of Illness															3 Mos. Later
	8	9	10	11	12	13	14	15	16	17	18	19	21	25	26	
Urine volume (cc.)	250	700	900	650	250	1,000	2,080	2,480	3,950	1,400	....	....	....	....	....	....
Nonprotein nitrogen (mg. per 100 cc.)	....	....	232	246	208	221	....	....	....	....	....	....	....	47	....	42
Creatinine (mg. per 100 cc.)	....	....	12.1	....	16.9	15.2	14.5	13.2	....	....	....	10	....	....	1.75	....
Carbon dioxide combining power (volume, per cent)	....	....	....	27	....	....	31	....	....	....	....	....	....	....	....	....
Serum chloride as NaCl (mg. per 100 cc.)	....	....	....	380	407	480	475	....	....	....	....	....	....	....	....	....
Serum potassium (mg. per 100 cc.)	....	....	....	....	....	....	20	....	....	....	....	....	....	....	....	....
Serum calcium (mg. per 100 cc.)	....	....	....	....	....	....	....	10.7	....	....	....	....	....	....	....	....
Leukocytes per cu. mm. (with percentage of polymorphonuclear cells shown in parentheses)	....	....	15,300 (p. 81)	....	....	16,600 (p. 90)	....	20,500 (p. 87)	....	....	19,800 (p. 76)	....	17,100 (p. 77)	11,100 (p. 73)	....	7,100 (p. 55)
Hemoglobin (gm. per 100 cc.)	....	....	11.2	....	....	7.1	....	10.7	....	....	13.3	....	....	12.7	....	12.5
Prothrombin (per cent of normal)	....	....	72	....	....	....	38	92	....	....	80	....	....	61	....	90
Albumin-globulin (gm. per 100 cc.)	....	....	3.7/2.2	....	....	....	....	....	....	4.5/2.5	....	....	....	....	....	....
Icteric index (units)	....	....	35	....	40	....	....	....	....	....	31	....	....	9.5	....	10
Cephalin flocculation (units)	....	....	3+ (24 and 48 hrs.)	....	....	....	....	....	....	....	....	....	....	Neg. 48 hrs.	....	....
Cholesterol-ester (mg. per 100 cc.)	....	....	....	153/33 =21%	....	....	....	....	....	....	....	....	....	270/187 =70%	....	301/260 =86%
Carbohydrate (mg. per 100 cc.)	....	....	....	117	....	....	....	....	....	....	....	....	....	....	....	....
Thymol turbidity (units)	....	....	5.2	....	....	....	....	....	....	....	....	....	....	....	....	....

Blood type "O", Rh+.

having drunk about two ounces of this ten days previously. This fluid contains 75 per cent carbon tetrachloride and 25 per cent naphtha by volume, and this fact confirmed what had become a strong suspicion of carbon tetrachloride intoxication.

On the 11th day the blood pressure was 150 mm. of mercury systolic and 60 mm. diastolic. There was a sinus rhythm with a pulse of 90 and temperature was 98.6° F. Edema of the face and back had developed and what one observer thought were spider angiomata were noted on the nose. No change in the liver was noted upon physical examination. The urinary output was 650 cc. in 24 hours. The serum chlorides were 380 mg. per 100 cc., so despite the presence of edema the patient was given 1 liter of 5 per cent glucose in Ringer lactate solution (containing 9 gm. sodium chloride) and 1 liter of 5 per cent glucose in water intravenously. In more detailed examination of the urine on this day, the following data (calculated on the basis of 24-hour urine excretion) were noted: Protein, 0.968 gm.; sodium chloride, 1.30 gm.; leukocytes, 36,000,000; erythrocytes, 60,000,000; casts (broad), 100,000.

On the 12th day the blood pressure was 160 mm. of mercury systolic and 60 mm. diastolic and the face was edematous. The abdomen was distended and the patient had black, liquid stools and bloody vomitus. Vitamin K again was given intravenously but severe nosebleed developed and blood and clots were "vomited." A large clot was noted in the nasopharynx, and there was active bleeding in the left naris. After the mucosa had been shrunk and old clots removed, no active bleeding point could be seen. A small ulcerated area was noted in the middle of the left septum, and the right middle turbinate appeared ecchymotic. There was no further bleeding. The pulse rate remained between 80 and 90 and the blood pressure did not fall so that the blood loss was thought to be unimportant. The urine was alkaline with a specific gravity of 1.010, and albumin 1-plus. There were three to four leukocytes and triple phosphate crystals per high power field. Because serum chlorides were still low (407 mg. per 100 cc.) the patient received 2 liters of 5 per cent glucose in normal saline by vein but excreted only 300 cc. of urine. The nonprotein nitrogen level fell but the creatinine rose (Chart 2).

On the 13th day there was no new bleeding but dark liquid stools were again noted. The blood pressure was 150 mm. of mercury systolic and 60 mm. diastolic and the pulse rate was 84, but as the hemoglobin content of the blood was 7.1 gm. per 100 cc., the patient was given 1,000 cc. of whole blood plus 1 liter of 5 per cent glucose in Ringer lactate solution (containing 9 gm. sodium chloride). The urine remained alkaline and the serum chlorides rose. The nonprotein nitrogen rose slightly but the creatinine fell. Urinary output was 1,000 cc.

On the 14th day the patient received an additional 500 cc. of whole blood plus vitamin K intravenously. Output of urine was more than 2,000 cc. The creatinine continued to fall and serum chlorides remained high but it was not until the 15th day that the patient showed clinical improvement; she was less nauseated and more alert and became interested in getting well. The blood pressure was 190 mm. of mercury systolic and 90 mm. diastolic. A few rales were noted at both lung bases. The creatinine content of the blood fell further and the hemoglobin value rose. The patient voided 2,500 cc. of urine. An additional 500 cc. of whole blood plus 1 liter of 5 per cent glucose in water was given.

On the 16th and 17th days proteins were given intravenously, and after that the patient was able to take nourishment by mouth. The remainder of the treatment is shown in the charts.

On the 22nd day blood pressure was 160 mm. of mercury systolic and 90 diastolic with a constant trigeminal rhythm. A soft systolic murmur was heard at the apex. The lungs were entirely clear. The abdomen was soft, and the spleen and kidneys were not palpable. The liver was 3 cm. below the right costal border on expiration and extended across the midline into the epigastrium with a sharp, non-tender edge. There was no icterus. Three days later, on the 25th day, blood pressure was 170 mm. of mercury systolic and 90 diastolic.

Results of urinalyses between the 17th and 25th days were: Specific gravity, from 1.001 to 1.009; reaction, neutral to alkaline; albumin, zero to 2-plus; leukocytes per high power field, 2 to many, and erythrocytes, 2 to 3. No casts were noted.

An electrocardiogram taken on the 22nd day showed sinus rhythm, rate 90, ventricular premature complexes occurring regularly every third beat, and inversion of T-2 and T-3. Subsequent electrocardiograms, taken two weeks and again two months later, showed T-2 upright, T-3 and P-3 inverted. The ventricular premature complexes remained but were less regular.

Upon subsequent examination two months after the patient had left the hospital and resumed moderate activity, there was a 4-pound gain in weight, blood pressure was 130 mm. of mercury systolic and 80 diastolic, trigeminal to bigeminal rhythm becoming regular after mild exercise, a softer systolic apical murmur, and a barely palpable non-tender liver edge.

Results of laboratory work not shown in Chart 2 but done three months after discharge from the hospital follow: Bromsulfalein test, no dye in serum after 45 minutes; erythrocytes, 3,940,000 per cu. mm. of blood; phenolsulfonphthalein excretion; 54.4 per cent in 2 hours after intramuscular administration of dye; Mosenthal test, concentrated specific gravity 1.017, diluted specific gravity 1.002; urine contained no albumin and 2 to 5 leukocytes per high power field; blood sedimentation rate, 46 mm. in one hour.

DISCUSSION

Most reported cases of carbon tetrachloride poisoning result from inhalation of vapors. Carbon tetrachloride, whether inhaled as fumes or ingested as liquid, characteristically damages the liver and kidneys. Whether or not the injury will be fatal depends primarily on the dose. Alcohol ingestion predisposes to more serious damage. Supposedly the liver is more severely damaged after ingestion of carbon tetrachloride and the kidneys are more severely damaged after inhalation.[2, 4, 5, 8, 9]

The renal disturbance is toxic nephrosis with damage primarily occurring in the epithelium of the distal tubules. Complete recovery occurs if the patient survives. The hepatic disturbance is essentially central necrosis of the lobule, with recovery if the patient survives.[1, 6, 7, 10]

The patient in the case here reported was not severely oliguric during the period of observation. There were relatively few casts and cells and relatively little protein in the urine, and the blood pressure was only moderately elevated. Yet edema was present and there was severe nitrogen retention and the content of chlorides in the serum and urine was low, indicating pronounced renal disturbance. Therefore the problem of whether or not to give sodium chloride was confronted. There is nothing definitive on this point in the literature, but most recent investigators would withhold salt in the presence of edema.[3, 6] The patient in the present case received 9 gm. of sodium chloride on the 11th day, 18 gm. on the 12th day and 9 gm. on the 13th day. Diuresis began on the 13th day.

The liver was badly damaged, as was indicated clinically by enlargement, tenderness, jaundice and hemorrhage. The

low cholesterol and esters, prothrombin disturbance and results of a cephalin flocculation test gave laboratory confirmation. The normal serum protein level illustrated the well-known fact that liver function may be differentially disturbed. The bleeding which was present was probably associated with the demonstrated prolongation of prothrombin time but cannot be more fully explained until knowledge of the entire prothrombin mechanism is more complete. Platelets and capillary fragility were normal.

The damaged liver needed protein as well as carbohydrate for regeneration and the patient received intravenous protein until the threat of death from kidney failure seemed more imminent than the threat of death from hepatic failure. No protein was given from that time (12th day) until there was evidence of kidney recovery (16th day). The transfused blood, which was given primarily to counteract the hemorrhage, may well have been an important factor in aiding renal recovery (the urinary output was greater the day preceding the hemorrhage than on the day of the hemorrhage and then increased greatly after blood was given).

In evaluating the effect of the treatment, it must be recognized that the patient was not observed by a physician until seven days after ingestion of the carbon tetrachloride. This perhaps indicates that under-treatment is of some value as contrasted to the temptation to do too much. The determining factor as to eventual outcome is the severity of the damage done to the liver and kidneys, and treatment is aimed at maintaining the body economy during the temporary illness of these vital organs. Administration of too much fluid and electrolyte cannot force the kidneys to function, but can drown the patient.

SUMMARY

A patient drank less than 6 ounces (the exact amount is not known) of a solution containing 75 per cent carbon tetrachloride. Nausea, vomiting and abdominal pain developed immediately. Subsequently jaundice, hypoprothrombinemia, and hemorrhage developed, and results of laboratory tests were indicative of liver damage. Oliguria, edema, azotemia, mild hypertension, hypochloremia, and acidosis due to kidney damage also developed.

Treatment consisted of cautious administration of moderate amounts of fluid and carbohydrates; sodium chloride was given when the serum chlorides were low; very little protein was given because of severity of the renal disturbances. Vitamin K and whole blood were also given. The patient recovered.

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The Significance of Pure Pigment Calculi in Biliary Operations

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Los Angeles

PIGMENT calculi in the biliary tract indicate an underlying hemolytic process. This process may be either familial or acquired hemolytic jaundice. Familial hemolytic jaundice has long been regarded as an entity apart from the acquired type. The familial type, first described in 1900 by Minkowski, is characterized by the presence of spherocytic erythrocytes in the circulating blood associated with increased fragility of the red cells. In the acquired type, first described by Hayem and by Widal, spherocytes are usually absent, reaction to Coomb's test is positive, and there is frequently a history of exposure to a hemolytic agent. The following case does not fit exactly into either category.

CASE REPORT

A 22-year-old white female had sudden onset of severe colicky pain in the right upper quadrant of the abdomen and radiating to the region of the right scapula. A few hours later nausea and vomiting began and 30 hours later generalized jaundice developed. The jaundice and pain in the right upper abdominal quadrant continued in varying degrees for three weeks.

At the age of 13 the patient had had jaundice associated with an enlargement of the spleen. A diagnosis of catarrhal jaundice was made at that time. At the age of 15 years she was found to have an enlargement of the spleen, associated with moderate anemia. At that time, erythrocytes numbered 2,500,000 per cu. mm. of blood. At the age of 19 years she was kicked on the upper abdomen by a horse. Because of the possibility of injury to an intra-abdominal viscus, exploratory laparotomy was performed. No ruptures were noted in the viscera, but there was a retroperitoneal hematoma. From that time until the present illness, splenic enlargement associated with anemia had been noted in periodic physical examinations. There was no history of drug idiosyncrasy or of the ingestion of drugs other than preparations of liver and vitamin B complex.

Careful interrogation concerning the family history elicited no evidence of jaundice or anemia in any of the patient's known ancestors.

Upon physical examination, tenderness to palpation was noted in the right upper quadrant of the abdomen. There was a long vertical scar of a right rectus incision. The spleen was palpable four inches below the left costal margin. Erythrocytes numbered 3,690,000 per cu. mm. of blood. The hemoglobin content was 11.6 gm. per 100 cc. of blood. Leukocytes were in normal number and the cell differential within normal limits. The erythrocytes were not abnormally fragile. No spherocytic erythrocytes were observed. There was bile in the urine. In a van den Bergh test there was an immediate direct reaction. Bilirubin content of the serum was 13.0 mg. per 100 cc. There were 8.2 gm. of total protein per 100 cc. of blood with a normal albumin-globulin ratio. Results of a cephalin flocculation test were negative. The prothrombin activity was 78 per cent of normal. In a roentgenologic examination of the gallbladder, after the administration of a radiopaque dye, multiple negative shadows, interpreted as multiple small stones, were noted.

At operation the gallbladder was found to be subacutely inflamed. The common duct was enlarged to twice normal size. Both the gallbladder and the common bile duct contained a considerable quantity of precipitated bile pigment and bile pigment stones. The pancreas was normal; the spleen was grossly enlarged, extending halfway to the umbilicus from the left costal margin. The gallbladder was removed, the common duct was opened, the stones and debris were removed from it, and a T-shaped rubber drain was inserted. The splenic artery was isolated and ligated at the superior border of the pancreas, and the spleen was removed after fractional ligation of the pedicle.

The calculi removed were made up of bile pigment. The changes typical of chronic cholecystitis were observed in the gallbladder. The spleen, which weighed 500 gm., measured 20 cm. x 11 cm. x 6 cm. In gross examination of sectioned splenic tissue it was observed to be homogeneous, smooth and deep red in color. It appeared moderately firm and contained much blood.

In microscopic examination of the splenic tissue, widely separated lymph follicles were observed and there was an abnormally large amount of blood throughout the organ. The pulp was laden with erythrocytes, the sinuses relatively free of them. Accumulations of hemosiderin pigment were observed throughout the tissue. There also appeared to be some increase in the amount of fibrous tissue.

Within a few hours of operation the hemoglobin content rose to 17.6 gm. per 100 cc. of blood and leukocytosis developed. A week later the hemoglobin content was 18.2 gm. per 100 cc. of blood and leukocytes numbered 31,200 per cu. mm. The temperature ranged between 99° F. and 101° F. daily. On the 12th postoperative day, right pleural effusion appeared; this was gradually absorbed.

Dismissed from the hospital on the 13th postoperative day, the patient then steadily gained in strength. The hemoglobin content of the blood steadied at around 14.8 gm. per 100 cc. The number of leukocytes steadily decreased toward a normal level.

DISCUSSION

The extensive surgical procedure carried out was indicated because of the different pathologic processes present. The gallbladder was removed because of the cholecystitis and cholelithiasis. The common duct was opened and the pigmented calculi removed from it because of the obstructive jaundice and biliary colic resulting from the presence of the stones. The spleen was removed in order to terminate the hemolytic process which resulted in the formation of the pigmented stones.

It must be emphasized that the presence of multiple pure pigmented stones in the biliary tract indicates excessive hemolysis. Boyd stated that no other cause of such stones has been established.

If the hemolytic process is in a stage of remission when a patient with biliary calculi of pigment type is first observed, the process may be overlooked. It is important that every effort be made to establish the presence of an underlying process by careful consideration of the past history and the results of present physical and laboratory examinations.

In the case here reported, the normal fragility of the red cells, the absence of spherocytic cells and the absence of a family history of hemolytic anemia militated against the diagnosis of familial hemolytic jaundice. A diagnosis of acquired hemolytic jaundice was rendered unlikely by the absence of a history of drug idiosyncrasy or of a history of the ingestion of noxious substances. The negative reaction to Coomb's test also tended to oppose such a diagnosis. The history of long-standing mild anemia associated with splenomegaly, followed by the development of pigment calculi, suggested the diagnosis of chronic hemolytic anemia. The observations in pathologic examination of the spleen were consistent with this. The effect of splenectomy on the anemia was similar to that observed when the spleen is removed in classic cases of congenital hemolytic jaundice.

In any patient with obstructive jaundice caused by pigment calculi, underlying hemolytic jaundice should be suspected. In such instances removal of the pigment calculi is insufficient therapy. Reformation of pigment calculi should be prevented by means of splenectomy.

SUMMARY

A case is presented in which obstructive jaundice followed the development of pigment calculi in the biliary tract. There was an underlying history of splenomegaly and anemia. The case was not typical of either familial hemolytic jaundice or acquired hemolytic jaundice. The response to splenectomy was that which usually follows this operation in cases of familial hemolytic jaundice.

Pigment calculi in the biliary tract indicate an underlying hemolytic process. The etiologic factor in this process must be sought and removed to prevent recurrence of calculi.

ACKNOWLEDGMENT

The authors wish to express their thanks to Leonard E. Croft, M.D., of Santa Monica, for permission to publish this case.

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Cytologic and Radiologic Observations in Lymphosarcoma of the Stomach

Report of a Case

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LYMPHOSARCOMA of the stomach is a relatively uncommon tumor, usually not diagnosed preoperatively,[2, 9] but since nearly 600 cases have been reported[12] in numerous excellent papers, the addition of a single case report could not be justified without good reason. The authors have seen no reports of cytologic examination of gastric contents in this disease, however, so the cytologic observations and radiologic features in the case herein reported were considered worthy of record.

Gastric lymphosarcomas are commonly located on the greater or lesser curvatures or on the posterior wall, with the orifices usually free.[8, 12] In contrast with carcinomas they originate in the submucosa and tend to ulcerate the mucosa late in the disease, but extension to the serosa with perforation occurs more commonly than in carcinoma.[2]

Symptoms are not characteristic and may suggest a peptic ulcer.[2, 10, 13, 14] On gastroscopic examination, a smoothly marginated polypoid submucous tumor covered by relatively normal mucous membrane, diffuse enlargement of rugae, and ulcerated lesions covered by a gelatinous secretion are suggestive of lymphosarcoma.[11, 13] Similar observations demonstrated by roentgenologic examination are also suggestive of lymphosarcoma, although it should be noted that these signs may occur also with carcinomas.[1, 3, 4, 5, 6, 7, 15]

REPORT OF CASE

The patient, a 31-year-old white male physician, entered the hospital on Sept. 12, 1949, complaining of diarrhea, progressive anorexia, and abdominal pain of six months' duration, with a weight loss of 15 pounds. The diarrhea was of the magnitude of eight to ten daily liquid stools, without mucus or gross blood. The pain was mainly on the right side of the abdomen, but tended to involve the entire abdomen when severe, and appeared about four hours after meals. It was relieved by ingestion of milk, cheese or Amphojel,® by atropine, or by a bowel movement. Alcohol, bulky food, and exercise aggravated the pain. In June 1949, thinking he had amebiasis, the patient treated himself with chloroquine, which relieved the symptoms for a few days. There was occasional vomiting. The patient had not been jaundiced.

Four years previously a similar episode of diarrhea, lasting three months, had occurred. No parasites were found at that time and roentgen investigation was reported to have indicated "gastrointestinal allergy." The axillary, cervical, and inguinal lymph nodes were known to have been enlarged for more than 20 years, but in the patient's opinion there had been no recent change in that respect.

The patient was well developed, but thin. Pallor was the most striking feature in his appearance. Several discrete cervical, inguinal, and left axillary lymph nodes 0.5 to 1 cm. in diameter, and a small left epitrochlear node were palpated. Mild mid-epigastric tenderness was noted. The hemoglobin content of the blood was 10.9 gm. per 100 cc. Leukocytes numbered 8,300 with neutrophils 76 per cent, lymphocytes 12 per cent, monocytes 7 per cent, and eosinophils 5 per cent. The packed red cell volume was 37 per cent of the whole blood. There was occult blood in one of three stool specimens. Gastric analysis showed 61 degrees free, 75 degrees total acidity. Results of thymol turbidity and flocculation tests were normal. The albumin and globulin contents of the blood and the ratio also were normal.

A massive fasting residue was observed in the initial roentgen gastrointestinal examination and at six hours there was 75 per cent barium residue in the stomach. Large rugae were observed, and there was a suggestion of a large shallow ulcer crater. In a roentgen examination, following a week of gastric lavage, a large ulcerating lesion (Figures 1 and 2) was observed on the posterior wall of the pars media of the

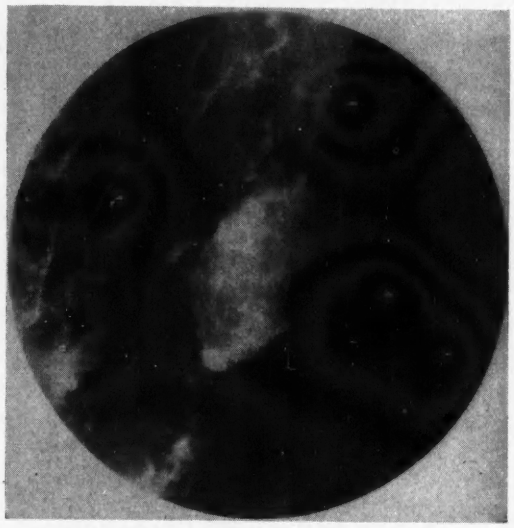

Figure 1.—Left anterior oblique spot film, showing crater and enlarged rugae.

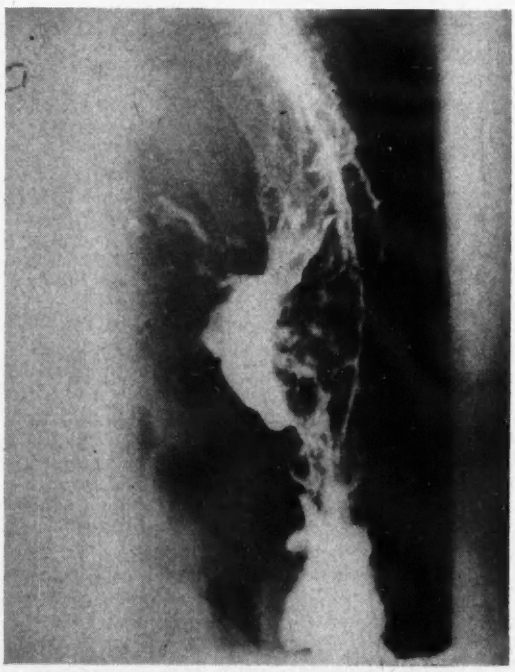

Figure 2.—Right anterior oblique spot film, showing posterior location of ulcer.

From the Departments of Pathology, Surgery, and Radiology, Letterman Army Hospital, San Francisco.

stomach, near the greater curvature, with enlargement of the rugae in the distal two-thirds of the stomach. There was no obstruction at this time. In a roentgen examination with barium enema a narrowing of the transverse colon near the splenic flexure, with no disturbance in the mucosa, was observed. This apparently was the result of extrinsic disease. The x-ray diagnosis was ulcerating lesion of the stomach.

In gastroscopic examination, generally enlarged gastric rugae and a large defect in the gastric mucosa were observed. The base of the ulcer was 5 x 4 cm. in diameter with heaped-up, irregular, and undermined margins, and a bloody exudate in several areas in the margins. The gastroscopic diagnosis was ulcerating lesion, most likely carcinoma.

Malignant cells were noted in microscopic examination of smears prepared from material obtained by gastric lavage, stained by the Papanicolaou technique, and a hematoxylin- and eosin-stained paraffin button. Partial gastrectomy with gastrojejunostomy was carried out Oct. 3, 1949.

At operation, a rough, nodular, brawny lesion was palpated along the mid-portion of the greater curvature. There were numerous enlarged lymph nodes around the pylorus, and others extended along the course of the aorta to the under surface of the diaphragm. The liver was apparently not involved. The lesion had penetrated the posterior stomach wall, perforated, and attached itself to the superior surface of the transverse mesocolon, causing the deformity of the transverse colon noted in x-ray examination. Grossly observed, the lesion was thought to be lymphosarcoma. Fifteen days after operation roentgen therapy, directed toward the periaortic nodes, was started.

Pathologic Examination: On Sept. 27 gastric lavage (referred to previously) was done and, after centrifugation, smears were prepared from the sediment and stained by the Papanicolaou technique, using EA65 as a counterstain. A paraffin button was prepared from the remainder of the sediment, and stained with hematoxylin and eosin. In microscopic examination of the smears (Figure 3) and paraffin button sections, numerous atypical cells, occurring singly and in small clumps, were observed. These cells were sometimes multinucleated but were usually mononucleated and the criteria of malignancy observed in them included prominent nucleoli, condensation and stringing of chromatin, dense, often irregular nuclear membranes, and abnormal nuclear-cytoplasmic ratio. These cells, although considered malignant, differed from those in epithelial malignant diseases of the stomach previously observed in this laboratory by virtue of the extremely vesicular nucleus. Hyperchromatism, commonly described in malignant cells in gastric washings, was not observed in this case.

The operative specimen submitted for pathologic examination (Figure 4) consisted of the greater portion of a stomach as well as a separate lymph node. In external examination of the stomach, the posterior wall was observed to be thickened, with a perforation near the greater curvature. A tumor mass measuring 16.5 x 15.5 x 2 cm. was observed on the mucosal surface. The rugal pattern adjacent to the tumor in general was accentuated, but alternating areas of smoothness and nodularity were observed in other areas.

Sections were taken through the ulcerated area, through the principal bulk of the tumor, and at both lines of resection. In the latter areas the stomach was free of tumor. The tumor of the stomach and the lymph node were similar in histologic appearance. In both there was widespread infiltration by mature and immature lymphocytes which involved all layers of the stomach (Figure 5). There was no increase in reticulum in either the lymph node or the sections from the stomach, and no atypical cells suggestive of Sternberg-Reed cells were identified. The diagnosis was lymphosarcoma of the stomach, with involvement of regional lymph nodes.

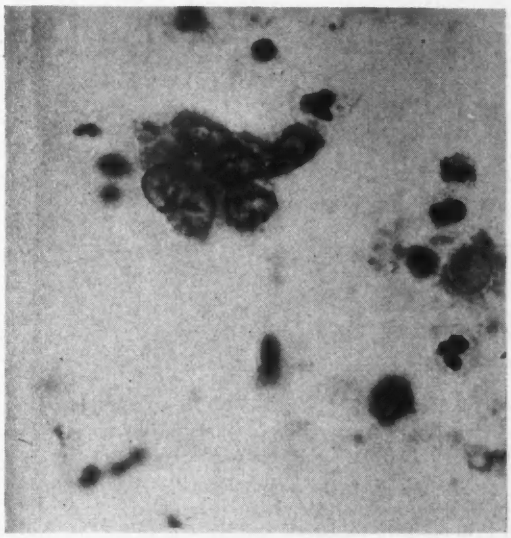

Figure 3.—Clump of malignant cells obtained by gastric lavage and stained by the Papanicolaou method (x 900).

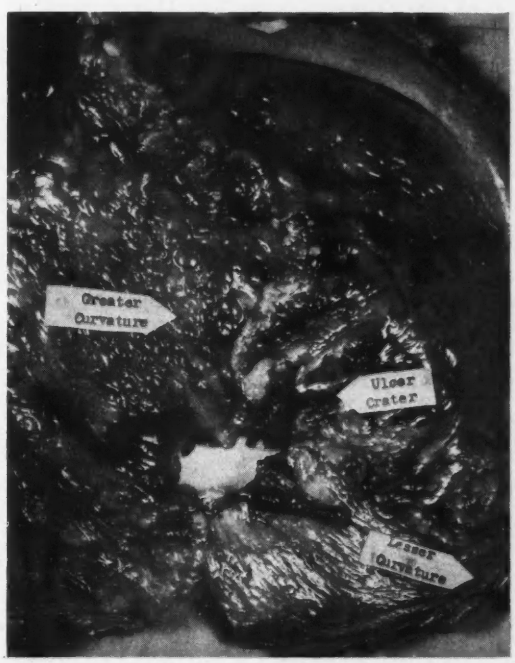

Figure 4.—Serosa of stomach, showing perforation and nodularity.

DISCUSSION

The clinical diagnostic indices of lymphosarcoma of the stomach are so similar to those of carcinoma that the true diagnosis may be given little consideration. Age appears to be the single factor which might arouse suspicion of lymphosarcoma in a patient who has pain suggestive of ulcer, with weight loss and anorexia, and an appearance suggesting

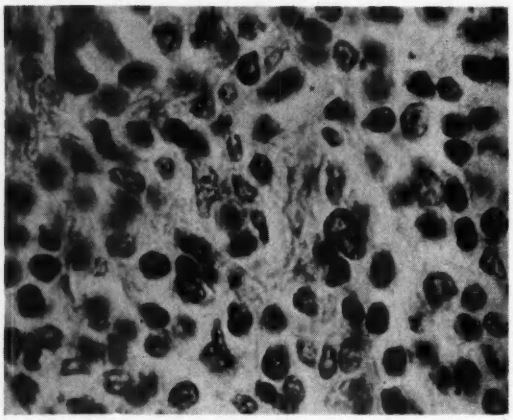

Figure 5.—Paraffin section through tumor. Hematoxylin- and eosin-stained (×900).

malignant disease. The physical findings may be minimal. Gastroscopy and roentgenology are of value in locating the disease, and in suggesting that the process may be malignant, but they are generally conceded not to replace histologic study for the differentiation of lymphosarcoma from carcinoma.

Although the cytologic examination of gastric washings in the case reported verified the preoperative clinical diagnosis of malignancy, it is believed that the procedure probably would not be too valuable in early diagnosis. The lesion does not involve the superficial structures of the stomach early, and it is probable that only after ulceration has occurred will malignant cells be recoverable from the gastric washings.

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California MEDICINE

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EDITORIALS

Medicine's Interest in the 1951 Legislature

California's State Legislature has now embarked on the second portion of its bifurcated session. In the first part, only emergency bills were acted upon and other proposals were introduced for consideration and action at the second part of the meeting.

Now, after a six-week recess, the actual work of passing, amending or rejecting the various bills is getting under way. The enormity of this project is apparent when it is realized that 5,167 proposed laws—a record high—were introduced in the first part of the session, with another 200 or so resolutions, constitutional amendments and other proposals also placed in the hopper. The legislators really have their hands full this year.

The record number of proposed laws brings forth two important thoughts by medical men and their allies. First, the tremendous job faced by the legislators, and the variety of proposals before them, argue conclusively for the maintenance of legislative representatives by special interests. No member of the Legislature can be expected to analyze every bill before him with a critical eye and with fair chances of picking up the multitudinous implications of the thousands of proposals. Where special or technical problems are present, it is incumbent on the professions or industries whose interests are affected to provide expert technical guidance for the legislators.

Second, the protection of the public health demands that the medical and allied professions act aggressively and courageously in meeting the numerous measures promoted by self-seekers. In the current legislative session 429 measures directly or indirectly affecting the practice of medicine or the public health were uncovered in a preliminary study of all bills. Further study of all measures, as time allows, continues to show additional proposals in this category and the total will probably run close to 600 before the session closes.

It is not the intent here to classify all these bills as the spawn of self-seekers; many of them are legitimate attempts to strengthen existing laws, to clarify misunderstandings and to make proper practice and adequate law enforcement easier for the profession and for the authorities. On the other hand, there is a multitude of measures now in Sacramento which would set up new classifications of the healing arts, would tend to make legal some practices which are now illegal or are in a shady land of indecision, or would establish new definitions of medical practice.

Many of the so-called fringe organizations seek to make their members physicians by law rather than by training. It is these groups which continue to foster legislation designed to put their members into a desirable legal and public classification and which, in the process, leave out of consideration the public interest and the public health.

The California Medical Association is fortunate in having a most efficient legislative committee of its members. Granted our Sacramento representatives have registered under the "lobbying" statutes; they are in Sacramento with a high purpose and with definite instructions as to the scope of their activities. Actually, they are watchdogs of the public health. The importance of their position cannot be overstated.

The Annual Session

May 13 to 16 will witness the Eightieth Annual Session of the California Medical Association. With due allowance for war periods and other obstacles, the numerical connotation of this meeting leads into the fact that the Association is now 95 years old and still growing lustily.

With its membership almost doubled in the past ten years and with a tremendous upsurge in state population figures, the C.M.A. each year faces new responsibilities in staging its annual meeting. For 1951 it appears that these responsibilities have been extremely well met.

The scientific program for the Los Angeles session has been arranged to permit free hours for viewing the exhibits, visiting or talking shop with friends, enjoying the recreational facilities of Los Angeles or just plain resting after concentrated effort. Speakers have been carefully selected, individual programs have been thoroughly and effectively arranged, and the timing of papers and programs has been set to insure a maximum of efficiency for the physician who wants to cover a variety of subjects.

As for exhibits, there will be a record number this year. All are screened for acceptability and all offer the busy physician a chance to condense a lot of postgraduate activity into the space of a few hours. The same is true for medical motion pictures.

On the business side, the House of Delegates meetings have been arranged to provide top efficiency for the House members, rather than an undue effort at the end of a busy day.

All in all, the 1951 Annual Session looks like an almost mandatory item on the calendar of any physician who can possibly arrange to attend.

CALIFORNIA MEDICAL ASSOCIATION

NOTICES AND REPORTS

Executive Committee Minutes

Tentative Draft: Minutes of the 225th Meeting of the Executive Committee of the California Medical Association, San Francisco, February 15, 1951.

The meeting was called to order by Chairman Lum in Room 218, St. Francis Hotel, San Francisco, at 2:15 p.m., Thursday, February 15, 1951.

Roll Call:

Present were President Cass, President-Elect MacLean, Speaker Alesen, Council Chairman Shipman, Auditing Committee Chairman Lum and Secretary-Treasurer Daniels. Absent for cause, Editor Wilbur. Present by invitation, Executive Secretary Hunton and Legal Counsel Hassard.

1. *California Taxpayers' Association:*

On motion duly made and seconded, it was voted to contribute $500 to the California Taxpayers' Association as a measure of appreciation for the services this organization has performed.

2. *California State Nurses' Association:*

Discussion was held on a request of the California State Nurses' Association for the inclusion of nursing in contracts issued by California Physicians' Service. It was pointed out that this was properly an item for consideration by C.P.S. and no action was taken.

3. *San Bernardino-Riverside Blood Bank:*

On the approval and request of the Blood Bank Commission, it was regularly moved, seconded and voted to extend a loan of $10,000 to the blood bank of San Bernardino and Riverside counties, legal counsel to handle details of the note and agreement for repayment.

4. *Doctor Lee Proposal:*

The committee discussed a proposal placed before the Council by Dr. Russel V. Lee. After discussion, it was regularly moved, seconded and voted to table this proposal pending receipt of additional details.

5. *Appropriation of Funds:*

Discussion was held on a suggestion by the Council Chairman for consideration of all requested appropriations by the Auditing or other committee prior to action by the Council. On motion duly made and seconded, it was voted to instruct legal counsel to prepare a by-law amendment to require the prior approval of a designated committee for the appropriation of any funds in excess of the budget and in excess of a designated minimum.

6. *Proposed Survey of Health Insurance Policyholders:*

It was regularly moved, seconded and voted to name Doctors Cass and MacLean to an advisory committee to an organization which proposes to survey the number of holders of voluntary forms of health insurance, the advisory committee to consider only the scope and form of the survey, not its detailed performance.

It was regularly moved, seconded and voted to instruct the Executive Secretary to secure cost estimates on other forms of spot checks of voluntary health insurance policyholders.

It was regularly moved, seconded and voted to table a proposal placed before the Council for a similar survey to be made by one of the universities.

7. *California Society for Medical Research:*

On motion duly made and seconded, it was voted to request the California Society for Medical Research to refer to the Committee on Public Policy and Legislation any item of proposed legislation or other matters of joint interest.

8. *Student American Medical Association:*

A request for the naming of California Medical Association representatives on local advisory committees of the Student American Medical Association was read and discussed and it was regularly moved, seconded and voted to refer this matter to the House of Delegates as a Council recommendation.

9. *Annual Conference of County Medical Society Secretaries:*

It was regularly moved, seconded and voted to hold the next Council meeting on March 17 and the Conference of County Medical Society Secretaries on March 18, in San Francisco. The Secretary was instructed to prepare the agenda for the conference.

10. *Committee on Scientific Work:*

The Secretary-Treasurer, as Chairman of the Committee on Scientific Work, asked approval of a long-standing rule of the Committee which requires that meetings of other scientific organizations be scheduled for the days preceding or following the Annual Sessions of the Association. On motion duly made and seconded, it was voted to affirm and enforce this ruling and to so advise the Secretary-Treasurer and the Editor.

11. *Proposed By-Law Amendments of Woman's Auxiliary:*

Two by-law amendments proposed by the Woman's Auxiliary were presented for Council approval, in accordance with constitutional requirements. These amendments dealt with routine changes to show the change in name of the magazine *Hygeia* to its new title of *Today's Health*. It was regularly moved, seconded and voted to recommend Council approval of these changes.

12. *Public Relations Proposal:*

It was regularly moved, seconded and voted to refer to the Committee on Public Policy and Legislation a proposed program of seeking endorsements for voluntary health insurance.

13. *Public Policy and Legislation:*

Discussion was held on four proposed legislative measures affecting the practice of physical therapy. It was pointed out that the Council had already approved two measures submitted in behalf of the American Physical Therapy Association, California division, and had disapproved two other measures submitted for another organization. It was regularly moved, seconded and voted to reaffirm this Council action, and the Executive Secretary was instructed to advise all Councilors as to the numbers of the specific measures approved and disapproved, as a means of eliminating possible confusion.

14. *American Medical Education Foundation:*

On the basis of expressions of opinion from selected county medical societies, it was regularly moved, seconded and voted to appropriate $100,000 to the American Medical Education Foundation.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 5:45 p.m.

DONALD D. LUM, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

Herbert C. Moffitt, Sr.

Reprinted, by permission, from *The Bulletin, San Francisco Medical Society*, March, 1951.

Herbert C. Moffitt, Sr. died at the University of California Hospital on February 5, 1951, after a short illness, thereby ending a fifty-year-long medical career which had encompassed essentially all the fields of activity in his chosen profession of medicine, and brought to him all of the honors and awards that can come to one in such a long active career.

Doctor Moffitt was born in San Francisco, December 9, 1867. After his preliminary schooling here he entered the University of California with the class of 1889. Early in his undergraduate career it was obvious that he was going to be an outstanding individual, for in the year of his graduation from the University he was class medalist: a medal awarded for outstanding leadership and scholastic ability. After receiving his bachelor's degree from the University of California, he went to Boston and there obtained his formal medical education at the Harvard University Medical School, winning the degree of M.D. in 1894. He served his internship in the Massachusetts General Hospital. With the early realization that additional knowledge and broad training in medicine were essential, he went to Europe and spent several years in postgraduate study in the various medical centers of the Old World, including Munich, Berlin, Paris and Vienna.

After this period of study, he returned to his native San Francisco to practice, and to begin the

long and eventful career of medical teaching and administration which made him so well known and loved by his students and associates. He obtained his license to practice in California in 1897. In 1898 he became a member of the San Francisco Medical Society, and was elected its president in 1915.

He was married in 1899 to Miss Marguerite Jolliffe. Mrs. Moffitt, a daughter, Mrs. Alice Trapnell, and a son, Herbert C. Moffitt, Jr. survive him.

Shortly after returning to San Francisco, and following his natural ability as a teacher, he became associated with the University of California in 1899 as lecturer in medicine. In 1900, he was appointed professor of medicine at the University of California. He was made dean of the medical school in 1912, which post he held until called to active duty. as a major, in the United States Army Medical Corps in 1918.

When, in 1911, the regents and President Benjamin Ide Wheeler deemed it advisable to reorganize the University of California Medical School, it was only natural that all should turn to Doctor Moffitt to direct this reorganization. As dean of the medical school at this time he made a tour about the country studying other medical schools, their administration, teaching, and research facilities. Shortly after he returned to San Francisco he brought to the University of California such men as George Whipple, Karl F. Meyer, Frank Lynch, Herbert M. Evans, and William P. Lucas. These men became heads of various departments and served long and actively in their positions.

Having enlarged the faculty, the next step was to enlarge the physical facilities of the medical school. The most obvious need was for a new teaching hospital. Doctor Moffitt went out almost alone among his friends and obtained from them funds with which to build and equip the present structure, which was completed in 1917.

It was only shortly after the new facility was finished that Doctor Moffitt left for his Army service. When he returned to the University to teach he became chairman of the division of medicine, as well as professor of medicine, which posts he held until 1927. He became emeritus professor of medicine in 1937, and after this, though theoretically in retirement, little was ever done or programmed at the medical school without consultation with the "Chief" as he had long since come to be known.

His prime interest during his entire career was the University of California Medical School, and nearly everything he did was influenced by his thoughts about it. It seems, therefore, indeed fitting that the new teaching hospital now being constructed on Parnassus Heights should be named the "Herbert C. Moffitt Hospital." When this announcement was made he was, in his self-effacing way, much opposed to accepting this honor but the University authorities insisted and the new building will bear his name.

In his actual professional work, Doctor Moffitt was primarily a clinician, and carried his exceptional clinical ability into all the work that he did, both as a background for his teaching and in his private practice. His fame spread early and he became one of the nation's best-known medical clinicians. He was a member of the Association of American Physicians and its president in 1922.

Always interested in medical education, he was an ardent proponent of the bedside method of teaching, and to all of his students and associates he will remain the clinical teacher *par excellence*. He, however, was not alone a bedside teacher but one who sought always to solve, by the research method, any problem which might arise. Because of this interest, he stimulated and directed many of his students and associates into serious research with the purpose of not only enhancing clinical knowledge but to advance the fundamentals of medicine also. His own research efforts were directed early toward pernicious anemia, coccidioides, and peptic ulcer.

It is extremely difficult to try to characterize an individual such as Doctor Moffitt, because of the unbounded energy and complex nature of the effort he put forth. He was possessed of a certain amount of apparent brusqueness and aloofness, both of which were but a thin cloak to cover up his highly sensitive and kindly nature. He was himself extremely punctual and always insisted on punctuality in his students, assistants, associates, and colleagues.

To him no problem was too small to merit complete attention, and at the same time there apparently did not exist a problem too large to be attacked. All who ever have had the privilege of observing him at the bedside, or in the consulting room, solving a difficult clinical problem by the method of direct attack, and examination and observation, rather than by the now much-used process of elimination, never would forget this incident of the highest educational value. Those in contact with him always recognized his phenomenal memory of medical literature and the cases which he had seen personally in the past. He was able always to call to mind, case details of patients seen in the long ago, or a medical article written years before, with an accuracy that astounded his listeners. He ever was eager to engage in new methods of case study and therapy but would never relinquish the tried and proven for the sake of that which was new—for the sake of its newness alone.

Doctor Moffitt's death has taken from our community a revered and beloved man, and from the University of California Medical School its foremost teacher and administrator. To his contemporaries, his associates, and his students, his passing seems to end an era. That source, to whom all might turn for aid in the solution of a problem of whatever medical nature, has been removed, and while there remain many individuals of the greatest ability in our community, few will enjoy the combined respect (which was near to reverence) and the confidence that all had in "The Chief."

EDWIN L. BRUCK

In Memoriam

BAILEY, FRANK J. Died in San Francisco, February 21, 1951, aged 75. Graduate of Cooper Medical College, San Francisco, 1899. Licensed in California in 1899. Dr. Bailey was a retired member of the Tehama County Medical Society, the California Medical Association, and an Associate Fellow of the American Medical Association.

✤

ENOS, MANUEL M. Died in Oakland, February 14, 1951, aged 75, of chronic myocarditis. Graduate of California Eclectic Medical College, Los Angeles, 1896. Licensed in California in 1896. Dr. Enos was a member of the Alameda-Contra Costa Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

GUNDRUM, WILLIS H. Died February 12, 1951, aged 89. Graduate of the University of Pittsburgh School of Medicine, Pennsylvania, 1891. Licensed in California in 1917. Dr. Gundrum was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

REY, HERMAN F. Died in Oxnard, February 21, 1951, aged 54. Graduate of the Universität Zürich Medizinische Fakultät, 1921. Licensed in California in 1922. Dr. Rey was a member of the Ventura County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

SCHERER, CARL A. Died in Marysville, February 12, 1951, aged 70, of obstruction of the common duct. Graduate of the University of Michigan Medical School, Ann Arbor, 1907. Licensed in California in 1945. Dr. Scherer was a member of the Yuba-Sutter-Colusa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

STEWART, BYRON L. Died in Beverly Hills, February 5, 1951, aged 47, of coronary occlusion. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1930. Licensed in California in 1939. Dr. Stewart was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

TUCKER, JAMES M. Died in Piedmont, February 18, 1951, aged 36, of coronary occlusion. Graduate of Jefferson Medical College of Philadelphia, 1941. Licensed in California in 1942. Dr. Tucker was a member of the Alameda-Contra Costa Medical Association, and an associate member of the California Medical Association.

Questions and Answers about C. P. S.

Question: **What accounts for the delays in receiving authorizations and payments which I have experienced lately under the Veterans Program?**

Answer: Recently, all medical records of veterans under treatment in Northern California were transferred by the Veterans Administration from C.P.S. offices at 450 Mission Street to the VA Regional Office at 49 Fourth Street. VA authorization officers also were transferred. Therefore, C.P.S. physician members' requests for authorization and vouchers for payment of services rendered must be relayed to the VA office by messenger, and then returned to C.P.S. offices. Physician members can be assured that any delays they have experienced recently in authorizations or payment have been unavoidable—and that these matters are handled by C.P.S. with all possible speed.

Question: **When a surgical procedure is unusually complicated, of longer than average duration and requires an unusual amount of aftercare, can anything be done to have a larger fee allowed—when I feel that the fee established by C.P.S. is not sufficient?**

Answer: Yes. Consideration will be given for higher fees in occasional cases of this kind.

In making payments under the C.P.S. fee schedule, it is recognized that certain cases will present greater difficulties and others will be less difficult. The fee schedule makes payments for average cases within the ordinary degree of variation. It is understood that there will be the occasional case that will require unusual or difficult management. In those instances, in warranted cases, adjustments in the fee may be made if a written report is submitted for consideration by the Medical Policy Committee.

Question: **If, in my professional opinion, the fee allowed for a specific procedure is wholly inadequate, would my views be considered? If so, to whom should I address my comments?**

Answer: Yes, physician members' comments relative to any item or items in the Fee Schedule are always considered. They should be sent to the C.P.S. Medical Director for forwarding to the Fee Schedule Committee.

The C.P.S. Fee Schedule is developed after extensive consideration and study by the Fee Schedule Committee and approved by the C.P.S. Board of Trustees. The Committee, appointed annually by the Council of the C.M.A., represents rural, urban and metropolitan medicine and surgery in the state. It is a permanently active group which keeps the Fee Schedule under constant study for the purpose of annual review, and fees are subject to revision by proper presentation to the Committee through the C.P.S. Medical Director.

Question: **From the physician members' point of view, what purpose is served by the county review committees?**

Answer: The county review committees, established in almost every county in the state, provide a permanent "sounding board" for the opinions of physician members in regard to C.P.S. policies and programs. The effectiveness of the committees is assured by the fact that they are appointed directly by each county society and are the recognized medium of bringing "grass roots" doctor opinion to the attention of C.P.S. Trustees. In short, each physician member is assured, by the democratically representative process of the county review committees, of a voice in the formulation and carrying out of C.P.S. policies.

Question: **As a psychiatrist, may I receive specialist's fees through the Veterans Program?**

Answer: Specialist's fees for psychiatry can be paid only to psychiatrists approved by the Veterans Administration. Approval may be obtained by submitting your qualifications to the C.P.S. Veterans Department in San Francisco, Los Angeles or San Diego. These qualifications are: (1) Certification in psychiatry by American Board of Psychiatry and Neurology, or (2) Possession of one of the following ranks in an accredited medical school—(a) any professional rank in psychiatry, (b) associateship in psychiatry.

Question: **Why are C.P.S. payments on accident cases slower than on other cases?**

Answer: There is always a slight delay in payment on accident cases, perhaps a matter of a few weeks, because of the possibility of third party liability in the accident.

If, upon investigation, C.P.S. finds there is no third party liability, payment to the physician is made without further delay. If there is third party liability and consequent additional delay in payment, the physician is so informed and is also advised of the pertinent legal aspects of the case which are of interest to him. If, ultimately, the third party liability is denied as the result of legal or other action, the physician is assured of payment from C.P.S. in accordance with the patient's contract and the C.P.S. Fee Schedule.

NEWS and NOTES

NATIONAL • STATE • COUNTY

ALAMEDA

A joint meeting of The Northern California Rheumatism Association and the Alameda-Contra Costa Medical Association will be held Monday, April 16, at 8:15 p.m., in Hunter Hall, 1025 Second Avenue, Oakland. There will be an informal panel discussion of Newer Aspects of Arthritis. Stacy R. Mettier, M.D., will be moderator, and members of the panel are Lowell A. Rantz, M.D., James F. Rinehart, M.D., Roland Davison, M.D., Ephraim Engleman, M.D., John J. Loutzenheiser, M.D., A. Justin Williams, M.D., and Frances Baker, M.D. Physicians are cordially invited to attend.

* * *

Dr. Edwin H. Lennette, chief of the Viral and Rickettsial Disease Laboratory, California State Department of Public Health, has been appointed for a five-year term as consultant to the Surgeon General, U. S. Public Health Service, on the Viral and Rickettsial Study Section, Division of Research Grants and Fellowship of the National Institute of Health.

LOS ANGELES

At a recent meeting of the **Los Angeles Society of Allergy,** the following officers were elected: Dr. M. Coleman Harris, president; Dr. Norman Shure, vice-president; Dr. Elizabeth Sirmay, secretary.

RIVERSIDE

The Riverside Regional Medical and Surgical Institute held January 25 and 26 was attended by 150 physicians from El Centro to San Bernardino and from Santa Ana to Needles. The meeting was one of a series of seminars arranged by the Committee on Postgraduate Activities of the California Medical Association. Lecturers for the program were members of the faculty of the University of Southern California School of Medicine.

SAN FRANCISCO

Dr. John W. Cline, President-Elect of the American Medical Association, will be guest of honor at a dinner Wednesday, April 18, at the Fairmont Hotel given under the auspices of the San Francisco Medical Society. Dr. Cline will be called upon to preview his aims with regard to A.M.A. policy when he is installed as President. A number of officials of the California Medical Association and of county medical societies will attend the gathering. Members of county societies who wish to be present may make reservations through the office of the San Francisco Medical Society, 2180 Washington Street, San Francisco; WAlnut 1-6100.

GENERAL

An **International Congress of Physical Medicine** (1952) to be held in London, July 14-19, 1952, has been announced by the British Board of Management of the International Federation of Physical Medicine, which is organizing the congress.

"In accordance with the regulations of the International Federation of Physical Medicine," the announcement said, "the meetings of the Congress will be reserved for matters dealing with the clinical, remedial, prophylactic and educational aspects of physical medicine and with the diagnostic and therapeutic methods employed in physical medicine and rehabilitation."

Applications for the provisional program of the meeting should be addressed to Dr. A. C. Boyle, Honorary Secretary, International Congress of Physical Medicine, 45 Lincoln's Inn Fields, London, W.C. 2.

* * *

The 1951 meeting of the **American Goiter Association** will be held in the Deshler-Wallick Hotel, Columbus, Ohio, May 24-26. The program for the three-day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

* * *

The Seventh Annual Meeting of the **American Society for the Study of Sterility** will be held June 9 and 10 at the Ritz Carlton Hotel, Atlantic City, N. J. Dr. Lewis Michelson of San Francisco is president of the organization.

* * *

Grants earmarked for support of specified physicians and their research were made last month to three California medical schools by the **John and Mary R. Markle Foundation.** The grants, which were among 20 awarded by the Foundation in its program "to keep young doctors on medical school teaching and research staffs," are for $30,000 each and are to be disbursed at the rate of $6,000 a year for a five-year period. Previous grants were for $25,000 for five years, and it was announced that, beginning July 1, the increase of $1,000 a year will apply also to the remaining period covered by current grants made in the last three years.

The three grants for instructors in California medical schools are:

Earl Eldred, M.D., intern, Virginia Mason Hospital, Seattle; after July 1, instructor in anatomy, University of California, Los Angeles. Anatomy and neuro-anatomy. Grant to University of California School of Medicine, Los Angeles.

Herbert Hultgren, M.D., instructor in medicine and pediatrics, Stanford University School of Medicine, and director of the Laboratory of Cardiovascular Physiology, Stanford Hospital. Internal medicine and cardiovascular disease. Grant to Stanford University School of Medicine.

Samuel J. Kimura, M.D., instructor in Ophthalmology, University of California School of Medicine. Ophthalmology; bacteriology, immunology. Grant to the University of California School of Medicine, San Francisco.

* * *

The program for the annual scientific meeting of the California Heart Association, to be held Wednesday, May 16, in Los Angeles, follows:

BILTMORE HOTEL, MUSIC ROOM
1:30 to 5:00 p.m.

1. Physiologic and Diagnostic Problems in Auricular Septal Defect—George C. Griffith, M.D., Richard S. Cosby, M.D., David C. Levinson, M.D., and Willard J. Zinn, M.D., Los Angeles.
2. Differential Diagnosis of Transposed Pulmonary Veins and Auricular Septal Defect—David C. Levinson, M.D., Los Angeles.

3. Correlation of the Electrocardiographic and Catheterization Findings in Right Ventricular Hypertrophy Due to Congenital Heart Disease—Richard S. Cosby, M.D., Los Angeles.
4. Pulmonary Stenosis—Sidney S. Sobin, M.D., and Walter S. Thompson, Jr., M.D., Los Angeles.
5. Clinical and Physiological Studies in Preparation for Commissurotomy in Mitral Stenosis—George C. Griffith, M.D., Los Angeles.
6. Diurnal Variation of Urinary Excretion in Normal Individuals and in some Edema-Forming Diseases—Ralph Goldman, M.D., and Samuel H. Bassett, M.D., Los Angeles.
7. A One-Year Clinical Follow-Up Study of SF 10-20 Lipoprotein Molecules in Atherosclerosis—Thomas B. Lyon, M.D., John Gofman, M.D., Ph.D., Frank Lindgren, B.S., and Hardin Jones, Ph.D., Berkeley.
8. Studies on The Shock Syndrome Produced by Experimental Myocardial Infarction in Dogs—Clarence M. Agress, M.D., Los Angeles.
9. Electrolyte Balance Following Human Myocardial Infarction: Evidence of a Probable Stress Reaction—John J. Sampson, M.D., Paul Toch, M.D., Meyer Friedman, M.D., Kalmen A. Klinghoffer, M.D., and Robert Kalmansohn, M.D., San Francisco.
10. Hyperventilation Syndrome in Functional Cardiovascular Disease and Its Relation to "Diaphragmatic Inertia" —Meyer Friedman, M.D., San Francisco.
11. Prostigmine Bromide Orally in the Prevention of Supraventricular Paroxysmal Tachycardia—Eugene B. Levine, M.D., Los Angeles.
12. Observations on the Action of Drugs in Complete Heart Block—Morris H. Nathanson, M.D., and Harold Miller, M.D., Los Angeles.
13. Further Experiences with the Use of ACTH in Rheumatic Fever—Jack A. Scheninkopf, M.D., Los Angeles.
14. The Innocuousness and Effectiveness of Lanatoside C in "Benign" Ventricular Tachycardia—Edward Shapiro, M.D., and Herman Weiner, M.D., Beverly Hills.
15. A Clinical and Experimental Evaluation of Khellin in the Treatment of Angina Pectoris—Herbert N. Hultgren, M.D., Leyland E. Stevens, M.D., and H. Schuyler Robertson, M.D., San Francisco.

POSTGRADUATE EDUCATION NOTICES

For more complete information as to fees and time of sessions address the institutions as listed.

THE COLLEGE OF MEDICAL EVANGELISTS

Endocrinology (8 periods). Dr. Julius Bauer. Tuesdays: 8:00-9:30 p.m., Room 3635, Los Angeles County General Hospital. April 3 through May 22, 1951. Tuition: $30.00.

This course is designed for the postgraduate student of internal medicine as well as the general practitioner. Special emphasis is placed on the practical application of glandular diseases to the everyday problems in medical practice.

Minor Orthopedic Surgery (8 periods). Dr. Alonzo J. Neufeld. Thursdays: 8:00-9:30 p.m. April 12 through May 31, 1951. Tuition: $30.00.

Subjects covered in this course will be those in which the general practitioner should have working knowledge, such as low back pain, arch strain, surgery of the hand and foot, besides the common lesions affecting the major joints of the extremities —shoulder, elbow, hip, and knee. Illustrated by anatomical material and slides, as well as clinical material.

Contact: H. M. Walton, M.D., 312 North Boyle Street, Los Angeles 33, California.

BOOK REVIEWS

PROGRESS IN GYNECOLOGY, Volume II. Edited by Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard Medical School; Chief of Staff of the Vincent Memorial Hospital, the Gynecological Service of the Massachusetts General Hospital; and Somers H. Sturgis, M.D., Clinical Associate in Gynecology, Harvard Medical School; Assistant Surgeon, Massachusetts. Grune & Stratton, New York, 1950. $9.50.

The second volume of "Progress in Gynecology" recently has come off the press, and, as the title indicates, we would expect it to be replete with new and useful information on all that has transpired in gynecology since the issuance of its predecessor in 1946. But alas, the few years that have gone over the hill have left us preciously little that could be considered new in concept or technique in the practice of gynecology, for as in all other branches of medicine, progress in gynecology comes in fits and spurts followed by long stretches of profound barrenness. A large portion of the new volume is not much different from the old one, albeit the editors state that much of the subject matter has been rewritten and that new chapters have been added. Yet the elaboration of old chapters and the unavoidable duplication resulting from having several authors treat the same subject has not particularly enhanced the value of the original intent to add to our current knowledge. And, although the second volume parades 250 pages more than its predecessor the reviewer does not find that the extra amount of print necessarily indicates progress but rather the more thorough reboiling of old bones. Taking a long view at the sincere intent of the editors to edify their readers one must conclude that the new book is not so much a second volume as an enlarged second edition.

Your reviewer has no quarrel with the content of the book. Its quality is good, although some chapters could have been treated with greater discretion regarding the relative value of certain diagnostic and therapeutic matters, for the book is meant to serve as a graduate text. Originally the "Progress in Gynecology" was meant to take the place of a "refresher" for those whose long absence with the military had disrupted their contact with gynecology; and its sale, and the willingness of the publishers to turn out a second volume, indicate that the book served its purpose at the time. That need has changed. As graduate information the "Progress" covers a wide range of information, largely of the standard type, and as a collection of personal views of 75 or more contributors it presents a fair cross-section of the thinking of Eastern gynecologists and some foreigners. If the title is not taken too literally, "Progress in Gynecology" makes good reading.

* * *

THE ANTIHISTAMINES, Their Clinical Application. By Samuel M. Feinberg, M.D., Associate Professor of Medicine, Saul Malkiel, Ph.D., M.D., Assistant Professor of Medicine, and Alan R. Feinberg, M.D. The Year Book Publishers, Inc., Chicago, 1950. $4.00.

This book provides a good comprehensive review of the antihistamines. It is concise and, for the busy practitioner, quite adequate. The authors, who are well suited to writing such a book, have covered the entire field of the antihistamines from their early conception to their growth as a $100,000,000 industry. One criticism which may be offered is that the section devoted to the history of the drugs is too brief for such an interesting topic.

In this book, the antihistaminics have very usefully been divided into three categories according to their parent structure. By following such a guide the practitioner can easily determine which particular drug to use in a given patient where a previously used antihistaminic has been found ineffective.

A very difficult problem has been attempted by the authors, namely, to list the various antihistaminic drugs in order of their effectiveness. Such an evaluation is very difficult, as the authors correctly point out, because among other reasons it depends upon which property of the antihistamine the particular investigator is attempting to measure, since it is definitely known that these drugs possess several properties apart from their histamine-inhibiting effect.

The authors have attempted, after much research, to condense into this small book most of the literature on the antihistaminics and to indicate our present day knowledge of them. This is by no means a reference book, nor is it intended to be, but it is ideally suited for the busy doctor who wants to acquaint himself with this large and relatively new subject. Numerous articles have been reviewed and a most extensive bibliography is included. Since the antihistamines are or have been employed in practically every branch of medicine, the authors have attempted to cover each specialty separately and to discuss briefly the merits of these drugs in the particular specialty.

The book is quite complete, consisting of a brief description of histamine, the chemistry and pharmacology of the antihistaminics, their clinical aspects and the toxic effects which may occur and which should be looked for following their administration. There is also included a handy table listing the various antihistaminics on the market and the dosage of each commonly employed.

All in all, it is well arranged, easy to read, concise, yet containing a great deal of information. This book is recommended to make us more aware not only of the indications but especially the limitations of the antihistamines.

* * *

THE MASK OF SANITY—An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality. By Hervey Cleckley, M.D., Professor of Psychiatry and Neurology, University of Georgia School of Medicine, Augusta, Georgia, Second Edition. The C. V. Mosby Company, St. Louis, 1950. $6.50.

This is a greatly enlarged second edition, much of which has been rewritten. The subtitle of the book, "An attempt to clarify some issues about the so-called psychopathic personality," describes the material given. The book starts out with a discussion of the problem of sanity and some discussion of the use of the term "psychopathic personality." There then follow nearly 200 pages of descriptions of actual clinical cases. Another 80 pages are devoted to comparing and differentiating the psychopathic personality from other abnormal mental conditions. About 40 pages are spent in a description as to what are the essential features in psychopathic personality. Following this, about 150 pages are devoted in an attempt to state what is wrong with these patients, what has brought about this condition, and what can be done about it. Views of other persons as well as of the authors are well presented, and there are 226 references.

Anyone who wishes to study the problem of the psychopath should read this book. It contains much valuable information, is presented in an interesting fashion, and is an important contribution to this whole problem.

THE MANAGEMENT OF OBSTETRIC DIFFICULTIES. By Paul Titus, M.D., Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh. With 446 illustrations and 9 color plates. Fourth Edition. The C. V. Mosby Company, St. Louis. 1950. $14.00.

This volume of more than a thousand pages has appeared in three previous editions and now is fairly well known to all obstetricians. In this latest edition certain new bits of information and a few revisions of opinions may be found in the sections dealing with abortion, placenta praevia, toxemia of pregnancy, induction of labor, pelvimetry, and obstetric anesthesia, just to mention a few. However, the additions appear to outstrip the revisions, with the result that the book is strangely uneven, retaining many outmoded notions and techniques but at the same time including much material of recent origin. It is unfortunate that the author so often has chosen to quote verbatim and at great length from periodicals and monographs rather than condense such material into a form more useful for one who is seeking a prompt and suitable way out of an "obstetric difficulty." The liberal use of quotation marks can quickly increase the thickness of a book without improving its literary qualities.

While the author takes pains to point out that this volume is not a textbook, since some of the conventional subjects have been excluded, there is little of importance in this book that cannot be found in any of the standard American obstetrical texts. And in at least some of the latter the quality of expression is far superior and perhaps less confusing to the general practitioner. Your reviewer has no quarrel with most of the sound and conservative views set forth in this volume, but he does feel that the text is in need of a severe pruning. To do justice to the intriguing title, the truly difficult obstetric problems should be better illuminated, and much of the boresome parade of standard facts and figures should be left to the sources from which they came.

It is noteworthy that Titus has agreed with the editors of two major obstetrical textbooks (Williams and DeLee-Greenhill) regarding uniform definitions for some of the classical obstetrical terms and prcoedures. This would seem to be a commendable move and should be welcomed by all teachers of the obstetric art since it may eliminate much of the senseless quibbling over minor variations in terminology. On the other hand, one might predict a certain amount of dissatisfaction with the new deal conjured up by these three self-appointed representatives. No set of definitions, however thoughtfully arrived at, could satisfy everyone concerned.

* * *

PRINCIPLES OF GENERAL PSYCHOPATHOLOGY—An Interpretation of the Theoretical Foundations of Psychopathological Concepts. By Siegfried Fischer, M.D., Clinical Instructor in Psychiatry, University of California, Formerly Professor of Psychiatry and Neurology, University of Breslau. The Philosophical Library, New York, 1950. 327 pages. $4.75.

In view of the many schools of thought in present-day psychological theory and practice, it takes courage to present a survey of psychopathological phenomena. This volume is divided into four sections. The first deals with fundamentals of psychopathological concepts—perception, thought, memory, consciousness, unconsciousness, apperception, orientation, emotion, volition, intelligence, language and their disturbances. The second part describes "comprehensible and causal connections" and those connections which become comprehensible through uncovering the unaware. Syndromes or symptom complications of mental disturbances are reviewed in the third section, and the abnormal personality, various types of personalities, the relation of personality to psychoses, and the differences between the neurotic and psychopathic personalities in the last section.

The author has made a sincere and conscientious effort to present his thesis in a well organized, lucid fashion, but the rather stilted, ponderous style and language interfere with the clarity of expression. For example, in describing the symptom in which schizophrenic patients complain of hearing their own thoughts, he calls this "Gedankenlautwerden"; the "relation of reference" is "Zuordnung"; "incoherence" is "Zerfahrenkert"; and "prolixity" is "Weitschweifigkeit." In the discussion of the agnosias and aphasias, the author might well have referred to the work of Henry Head in England and to J. M. Nielsen in this country. An attempt is made to differentiate feeling, affect and mood, but this is not too clear. For instance, "Feelings are related to objects, while affects are relative to 'Sachverhalt.'" The author bases his "dynamic" psychology on what he calls "comprehensible" connections, in contrast to the "causal" approach and method of investigation of the natural sciences. "Psychoanalysis, therefore, is based on comprehensible, not causal, connections, dynamic psychology is based not on the causal principle but the principle of meaning and purpose." It is emphasized that certain connections may become comprehensible through uncovering what is repressed and unaware. In neurotic reactions, anxiety arises from the child's feelings of helplessness. This feeling of helplessness and concomitant feelings of inferiority are regarded as the most profound trauma in the lives of many neurotics, and the author criticizes Freud for regarding "children's needs as exclusively sexual" and overlooking and failing to explain the origin of inferiority feelings. There are many psychoanalysts who would quarrel with such a criticism.

The author believes that "in psychopathology and in psychiatry we assume that all mental processes have a physical basis." He firmly believes, and he has done considerable investigation in this field, that "there is a connection between the anterior lobe of the pituitary, the metabolism, and the psychotic symptoms of schizophrenia." In the discussion of hereditary factors in mental illness, the author fails to mention Kallman's painstakingly detailed studies of identical and non-identical twins suffering from mental illness. Many authors would quarrel with the author's statement that the psychopathic personality has an "innate" predisposition.

There is much that is dogmatically presented and is still quite controversial in this volume on psychopathology. For this reason it is not considered appropriate reading for the medical student. For the general medical man it may be regarded as too technical, and the psychiatrist would find much with which he would disagree. Nevertheless, it provides stimulating reading for those who are interested in psychopathological descriptions and theories.

* * *

THE LOW FAT, LOW CHOLESTEROL DIET—What to Eat and How to Prepare It. By E. Virginia Dobbin, Senior Dietitian, E. V. Cowell Memorial Hospital, University of California, Berkeley; Helen F. Gofman, M.D., San Francisco; Helen C. Jones, Home Economist, Berkeley; Lenore Lyon, San Jose; Clara-Beth Young, Dietitian, E. V. Cowell Memorial Hospital, University of California, Berkeley. Doubleday & Company, Inc., Garden City, N. Y., 1951. 371 pages. $3.45.

The authors have compiled a practical handbook and cookbook on the low-fat, low-cholesterol diet. The presentation is simple and direct, and the text is aimed at answering specific questions concerning *how* such a diet can be constructed without burdening the reader with medical reasons. Details are given on recipes and methods of preparation and cooking of foods to make them palatable although low in fat. The book is well organized, easy and simple to read. It is designed primarily for the housewife.

SAVILL'S SYSTEM OF CLINICAL MEDICINE—Dealing with the Diagnosis, Prognosis, and Treatment of Disease for Students and Practitioners. Edited by E. C. Warner, M.D., F.R.C.P., 13th Edition. The Williams and Wilkins Company, Baltimore. 1950. 1,198 pages. $7.00.

The reviewer cannot recommend this book for either American medical students or practicing physicians. For a textbook of medicine to survive many decades through many editions, it requires an ability of the authors to discard the insignificant and emphasize the significant. With the ever-accumulating mass of clinical data, this is a duty the authors owe the reader. This textbook of medicine, however, in its 13th edition, still advocates drugs and methods of procedure that very few modern American physicians employ. Also in many instances the nomenclature as regards classification of syndromes is unwieldly. For instance, angina pectoris is still classified into four types: (1) Angina of effort, (2) spasmodic angina, (3) coronary thrombosis (status anginosis), and (4) angina innocens (pseudo-angina). This is confusing rather than clarifying, both to the student and physician. Drugs such as sulfonal, trional, and calomel which few American physicians have employed for years are still advocated. Other modes of therapy which are seldom used are advocated: On page 879, under the treatment for Meniere's disease, it is said that "blistering the mastoid may help others"; on page 514 under the treatment of anuria, "cupping, wet or dry, over the loins relieves local congestion" is another suggestion; the application of leeches "to the precordium is recommended for relief of pain of acute pericarditis" is also suggested.

The value of most books depends upon the sagacity of the authors in emphasizing the important and de-emphasizing the unimportant. It would appear that there has been little of the latter in this book. It would appear to the reviewer that this book needs intensive re-editing, with a ruthless excision of much of its obsolete material. Otherwise in his opinion this book cannot long appeal to the modern physician.

* * *

BLOOD TRANSFUSION. Edited by Geoffrey Keynes. The Williams and Wilkins Company, Baltimore, 1949. $12.50.

This book deals with all the multi-faceted problems pertaining to blood banks, and it is most pertinent because the English school of hematologists has long performed meticulous research work in all phases of blood procurement, processing, and distribution. This book maintains the high standard of work which is so characteristic of the English school. The book cover is solid, the binding is substantial, therefore the volume will withstand considerable hard use. This book will find an immediate place on laboratory shelves, for its physical sturdiness will give hard service through the years. The printing is most legible, clear-cut and nicely spaced for ease of reading.

Various men well known in their respective fields have contributed to the completion of this fine work. It was edited by Geoffrey Keynes. His former book on blood was printed 28 years ago and is still worth reading. The present edition is broken down into separate chapters, each one contributed by an expert in the field. One would suppose there might be a lot of repetitious detail, but the little repetition that does occur only serves to heighten the readability of the book. It was a matter of gratification and considerable pride to read of the inclusion of many of our American research workers. The book culls widely and intelligently from the world's literature and is catholic in that respect. This fact makes the book more authentic for those dealing with blood transfusions.

It is a real pleasure to recommend this book to all laboratory technicians, interested medical personnel, and others working in blood banks throughout the country. It will be a valuable addition to the library of anyone working in blood dyscrasias. It is particularly applicable at this time due to the widespread interest in blood, plasma, and blood derivatives during this episode of international uneasiness. Dr. Keynes and his colleagues are to be highly commended for writing such a readable, authentic book and for this new approach to the fascinating and constantly enlarging field of blood banking. The volume does not answer all questions relative to this subject but it is provocative and should stimulate a considerable amount of research work in hematology.

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PRINCIPLES OF INTERNAL MEDICINE. By T. R. Harrison, M.D., Editor-in-Chief, Southwestern Medical College; with Editors Paul B. Beeson, M.D., Emory University Medical School; William H. Resnick, M.D., Stamford, Conn.; George W. Thorn, M.D., Harvard University Medical School; M. M. Wintrobe, M.D., University of Utah Medical College; and 48 Contributing Authors. 245 Illustrations. The Blakiston Company, Philadelphia, 1950. $12.00.

This is a textbook with a fresh approach to internal medicine, unhampered by the tradition of what a textbook should be like. The thesis of the book is that the classic presentation of medicine, with primary emphasis on specific disease, is inadequate and that the student cannot be expected to recognize or to manage the various manifestations of disease intelligently unless he also understand the basic mechanism of its cardinal manifestations. An attempt has been made to integrate the pertinent content of the preclinical sciences with clinical medicine, and to do this not only from the standpoint of disorders of structure, but also by way of abnormal physiology, chemistry and disturbed psychology.

The subject matter is divided into some seven parts. The first of these is on cardinal manifestations of disease and includes discussions of the major symptoms and signs and the mechanisms whereby these develop; the second part deals with certain physiological considerations which are especially germane to internal medicine; the third is concerned with reactions to stress and to antigenic substances.

The arrangement of the last four parts of the book is more like that of the conventional text of medicine, proceeding from disease condition to disease condition: Part four deals with metabolic and endocrine disorders; part five with disorders due to chemical and physical agents; part six with diseases due to biologic agents and part seven with diseases of organ systems.

The book is very bulky, its 1,600 pages giving the appearance of a large dictionary. Division into two volumes would make for easier handling. In spite of this, it is not (admittedly) all-inclusive, although one might expect it to be. And although it gives a scientific underpinning to the student it is sometimes not too practical in its discussions. A few of the accounts of specific diseases do not seem as good to this reviewer as those in more conventional texts: To illustrate, the author of the chapter on the diseases of the pancreas states with regard to acute pancreatitis that "tenderness and rigidity may be detected in the epigastrium or right upper quadrant" (not the left), and that the amylase "is increased only during the early course of the disease" and suggests that the condition may be treated either medically or surgically with equal benefit. Recent experience is surely against these views.

On the whole, the authors and editors have done an excellent job. They appear as interested in such a drab but common condition as back pain as they are in such a dramatic one as pericarditis. Throughout, emphasis is laid on the mechanisms underlying disease and disease conditions. The reviewer can recommend this book for every internist interested in the scientific approach to his art. He, likewise, predicts that within two years it will be the most widely used text on internal medicine.

"YOUR PROSTATE GLAND"—Letters from a Surgeon to his Father. By Reed M. Nesbit, M.D., Professor of Surgery, University of Michigan Medical School, Chief, Section on Urology, University Hospital, Ann Arbor, Michigan. Charles C. Thomas, Springfield, Illinois, 1950. 50 pages. $2.00.

This little volume (50 pages) consists entirely of a series of seven unedited personal letters written by one of our prominent urologists explaining to his own father the problem of "prostate trouble" in the elderly male. The text is accompanied by several simple outline drawings of an explanatory nature. The book is by no means a complete exposition of prostatic disease, for the author limits himself entirely to the obstructive phenomena and their relief especially by operation. It is simply and accurately written, in a form that will appeal to the lay reader psychologically, and warns the father (and hence the reader) against any attempt at self-diagnosis and self-treatment. He is advised to consult and be guided by his physician.

Dr. Nesbit is one of the country's outstanding proponents of the transurethral resection of the prostate, and the author of an excellent book on the technique of the operation. Hence, despite his effort to be fair in his discussion of the other methods of prostatectomy, his personal preference is evident. The book is designed to be read primarily by men interested in or already suffering from prostatism, who will doubtless be influenced, whether wisely or otherwise, in favor of the transurethral technique, even though he does discuss the possible limitations of the operation. He considers the perineal approach applicable only for limited special indications, an attitude with which some of his friends will not entirely agree.

The urologist who personally favors the suprapubic method, or especially transurethral resection, can profitably recommend this little monograph to his elderly patients, especially to those who are prospective candidates for prostatic surgery. Since it is such a small volume its value might even be increased if it could be published in a paper-bound edition for gratuitous distribution to such patients.

* * *

PATHOLOGIC PHYSIOLOGY: MECHANISMS OF DISEASE. Edited by William A. Sodeman, M.D., F.A.C.P., The William Henderson Professor of the Prevention of Tropical and Semi-Tropical Diseases, Tulane University of Louisiana School of Medicine. W. B. Saunders Company, Philadelphia, 1950. $11.50.

This volume is a collaboration by 25 authors on disturbances in the structural and physiological pathology of the various organ systems of the body. It endeavors to bridge the gap between texts of physiology and medicine by presenting a clinical picture of disease seen as physiological dysfunction. An attempt is made to explain how and why symptoms appear, so that the student or physician may have a rational interpretation of his findings.

In general the contents are clearly presented. The concepts are modern, sometimes original, practically always in keeping with accepted recent investigation. There are a commendable number of clarifying diagrams and charts. An up-to-date bibliography is published at the end of each section. The general makeup and the printing are good. Comprehension of the book will give the student and practitioner a measure of understanding of the principles underlying disease states in the body.

An interesting comparison may be noted between this book and Best and Taylor's "Physiological Basis of Medical Practice." The latter, which covers similar territory (though in more inclusive manner) is written by physiologists who approach the clinical from the basic science point of view. "Pathologic Physiology," on the other hand, is written by clinicians, each of whom has explored the basic science aspect of his subject.

THE URINARY FUNCTION OF THE KIDNEY. By A. V. Wolf, Ph.D., Associate Professor of Physiology, Albany Medical College, Union University. Grune and Stratton, Inc., New York, 1950. $7.50.

This splendid book, by an active physiologist who has himself made important contributions to the subject, discusses renal function from the standpoint of regulation of the organism's internal environment rather than from the currently fashionable concept of clearances (although the latter are not ignored). The chapters are concerned with water balance and fluid transfer, regulation of body volume, body water compartments, hydration and dehydration, diuresis and diuretics, antidiuresis and antidiuretics, the endocrines in urinary function, the clearance concept, renal osmotic work, urinary specific gravity, and tests of renal function. The approach is scholarly and thorough.

The average physician will be disconcerted by the mathematics and by the use of unfamiliar words and phrases such as "minimal isorrheic concentration." It would indeed be unfortunate if he were thus driven away from these pages, for in them is a wealth of material applicable to the problems of edema and of states with depletions of water or electrolytes. The book is highly recommended for all medical libraries and students, physiologists and pharmacologists, as well as to those clinicians interested in abnormal accumulations or losses of body fluids.

* * *

THE COMMON INFECTIOUS DISEASES—A HANDBOOK FOR STUDENTS AND POSTGRADUATES. By H. Stanley Banks, M.A., M.D. (Glas.), F.R.C.P. (Lond.), Physician-Superintendent, Park Hospital, Hither Green, London. The Williams and Wilkins Company, Baltimore, 1949. $4.50.

This small volume is a most scholarly review of common communicable diseases. The fact that it was published in 1949 is little drawback to its usefulness. Only the most recent advances in antibiotic therapy are lacking (and what textbook can keep abreast of antibiotic therapy?)

The author's experience as director of large isolation hospitals in England for more than 20 years is reflected in his discussion of pathology and of differential diagnosis. Among specific topics which are examined in detail are the intensive intravenous antitoxin treatment of hypertoxic diphtheria, the cerebral and adrenal pathologic changes in meningococcal infections, and the dangers of atelectasis and subsequent bronchiectasis in whooping cough. The completeness of this little book is attested to by inclusion of such subjects as infectious mononucleosis, infectious lymphocytosis, erythema infectiosum, and the congenital defects of infants resulting from maternal rubella. The chapter on infectious diarrheas of infancy is excellent.

This book is recommended to general practitioners, internists and pediatricians.

* * *

LANGUAGE FOR THE PRESCHOOL DEAF CHILD. By Grace Harris Lassman, Teacher of the Deaf; formerly Instructor of Speech, John Tracy Clinic, Los Angeles, Grune & Stratton, New York, 1950. $5.50.

An excellent guide for the parents of a deaf child. Such parents face a tremendous adjustment and need help which all too often the doctor does not give them. Even otologists often fail to put the problem in the proper perspective and seldom can give practical advice in the training of a deaf child. This book is arranged for the parent, with step-by-step instructions, illustrations, and examples of home training exercises and methods, but it should be read by doctors as well, for a better appreciation of the problem. The excellent bibliography of 223 titles includes almost all of the important articles with a bearing on training the deaf child.

RESEARCHES IN BINOCULAR VISION. By Kenneth N. Ogle, Ph.D., Section on Biophysical Research; Research Consultant in the Section on Ophthalmology, Mayo Foundation and Mayo Clinic, Rochester, Minn. Illustrated. W. B. Saunders Company, Philadelphia, 1950. 345 pages. $7.50.

This book is a very able discussion of the basic physiology involved in binocular visual processes by one of the foremost authorities in this field. It is well illustrated with diagrams and contains many graphical summaries of the material presented. It is not easy reading, although this is a fault of the material and not of the author. Much of the material was heretofore available only in the original works of Helmholtz, Hofmann, Bielschowsky, Hering and Tschermak. To this, Dr. Ogle has added the original work of the Dartmouth group—much of it his own.

Although the literature and texts on the anomalies of binocular vision are quite adequate from a clinical point of view, very little is written about the basic physiological principles in normal binocular vision. This book fills that need. Here, for the first time in English, between the covers of a single book, the most pertinent parts of this subject are ably presented by an authority. The text is divided into four parts: The first deals mainly with studies of the horopter and the theory of corresponding retinal points. The second part takes up fusional processes with a discussion of Panum's areas, fixation disparity, peripheral retinal fusion, and cyclofusional eye movements. The third part deals mainly with space perception, the induced effect and the changes incident to asymmetrical convergence. Part four is a complete discussion of aniseikonia.

This book will be of little aid to the clinician seeking a brief summary of how best to treat binocular anomalies. However, it will be indispensable to those interested in the physiological processes of binocular vision and is certainly the most complete and authoritative work in this field in recent years.

* * *

METHODS IN MEDICAL RESEARCH — Volume 3. Ralph W. Gerard, Editor-in-Chief. The Year Book Publishers, Inc., Chicago, 1950. 312 pages. $7.00.

CALIFORNIA MEDICINE favorably reviewed the two earlier volumes in this series which is devoted to the exposition of certain methods used in medical research. The present volume appears to rival the first two in quality of its presentations, but the subjects selected seem rather more specialized and likely to interest fewer physicians. The first section deals with methods for the study of the genetics of microorganisms; it should interest microbiologists, geneticists and biochemists. The second section is concerned with the assay of neurohumors; acetylcholine and the cholinesterases receive much attention, while two chapters describe methods for the estimation of substances liberated by adrenergic nerves and of adrenaline and nor-adrenaline in tissue extracts. The third section discusses selected psychomotor measurement methods, with subdivisions on physical work and strength tests, reaction time, coordinated motor responses, manual dexterity, eye-movement coordinations, and motor tests of laboratory animals. The final section is devoted to methods for the investigation of peptide structure.

As in the earlier volumes, each chapter is written by an authority, although there are fewer comments by others than in the previous books. The methods appear to be given in adequate detail, with appropriate bibliographies, author index and subject index. The book is recommended for purchase by libraries and for perusal by medical and other scientists, a few of whom will wish to have copies in their laboratories or on their desks.

A SYNOPSIS OF OBSTETRICS AND GYNAECOLOGY. By Aleck W. Bourne, M.A., B.B., B.Ch. (Camb.), F.R.C.S. (Eng.) F.R.C.O.G., Consulting Obstetric Surgeon, Queen Charlotte's Hospital, London. Tenth Edition, Fully revised. The Williams and Wilkins Company, Baltimore, 1949. $4.50.

Bourne has written a true synopsis of obstetrics and gynecology. There are certain terms, such as auto-intoxication, pelvic presentation and epimenorrhea, which are seldom used in American obstetrical literature. The classification of toxemia is quite different from what we are accustomed. The mortality with a modified Stroganoff regimen, as reported by the London Committee, is considerably higher than reported in this country.

Under abnormal pregnancy treatment of threatened abortion, Antuitrin S in doses of 100 units daily for a week without mentioning the use of corpus luteum or stilbestrol seems inadequate. The treatment of inevitable abortion with intra-uterine glycerine or introduction of tents is seldom if ever practiced in America.

In the synopsis, gynecological anatomy is clear, concise and exceptionally well organized.

There could be no dispute with the management of fibromyomas. It is surprising that no mention is made of carcinoma in situ in the chapter on malignant disease. Particular attention should be called to the excellent outline of etiology, symptoms, and treatment of displaced uteri.

This book fulfills the purposes of the author. It reviews quite thoroughly all phases of obstetrics and gynecology, although there is very little new added to the many fine texts now available.

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THE PROSTATE GLAND. By Herbert R. Kenyon, M.D., Associate Clinical Professor, Department of Urology, New York University, Bellevue Medical Center. Random House, New York, 1950. $2.95.

This little volume is an effort to explain to the lay reader in simple terms the anatomy, physiology, and diseases of the prostate gland. That most men, and even some women, are interested in the subject cannot be denied, and the author says in his foreword that he presents such information "in a form which any intelligent and interested layman can understand." In an organ the function of which is somewhat obscure even to the average medical man, there may be some doubt as to how fully many of his readers will comprehend even its simple terminology. The book is not intended for the physician, who will discover little or nothing new in its pages, but even he may find in the chapters on functional and infectious diseases information that will enable him to explain more adequately the bizarre symptoms frequently associated with these conditions.

One thing may be definitely said for the book. It is perfectly ethical and scientific, with nothing of the sensational or pornographic. It protests strongly against the nostrums and quackery too often associated with genital disease and brings these problems out into the light. Repeatedly the reader is encouraged to consult his physician, and no encouragement is given to self-diagnosis and self-treatment. Discussion of treatment is too sketchy to make the patient critical of his doctor's methods. The only possible exception is the rather full description of the various techniques of prostatic surgery, the choice of which is really a matter for mature surgical judgment.

On the whole this is a book which may, with possibly certain reservations, be recommended by the physician to the average interested patient with a high average intelligence, with the expectation that he will be able to read for himself something reasonably accurate and informative on the subject.

PROGRAM AND PRE-CONVENTION REPORTS

for the

CALIFORNIA MEDICAL ASSOCIATION

Eighteth Annual Session

Los Angeles, May 13—May 16, 1951

Biltmore Hotel

INDEX

PRE-CONVENTION REPORTS

Cancer Commission Pre-Convention Conferences, Page 322

Guest Speakers

CYRUS C. STURGIS

HERBERT C. MAIER

MACDONALD CRITCHLEY

Guest Speakers

CHARLES GORDON HEYD, M.D., New York, New York—President, United Medical Service, Inc.

HERBERT C. MAIER, M.D., New York, New York—Assistant Clinical Professor of Thoracic Surgery, Columbia University College of Physicians and Surgeons.

CYRUS C. STURGIS, M.D., Ann Arbor, Michigan—Professor of Internal Medicine, University of Michigan Medical School.

JOHN B. CAFFEY, M.D., New York, New York—Professor of Clinical Pediatrics, Columbia University College of Physicians and Surgeons.

MACDONALD CRITCHLEY, M.D., F.R.C.P., London—Dean, Neurological Institute.

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Lyle G. Craig	James L. Bray
Frank G. Crandall, Jr.	H. B. Breitman
Philip J. Cunnane	John W. Budd
J. M. de los Reyes	John A. Bullis
Douglas Donath	John L. Caster
Frederic Ewens	Rafe C. Chaffin
Paul D. Foster	Finis G. Cooper
Charles W. Gilfillan	Edward H. Crane, Jr.
Willard M. Gobbell	John S. Darby
Victor Goodhill	John H. Davis
William E. Graham	James C. Doyle
Richard A. Griffin	Charles V. Emerson
Robert B. Haining	William D. Evans
John B. Hamilton	Alvin G. Foord
J. Severy Hibben	Wells E. A. Forde
Lawrence M. Hill	Percy A. Foster
Eugene F. Hoffman	Garland F. Garrett
Elizabeth Mason Hohl	Frederic J. Gaspard
Robert B. Hope	William H. Grishaw
Carl R. Howson	Frederick G. Gruber
Arthur H. Hurd	Francis E. Guinney
Joel S. Kelsey, Jr.	Ernest M. Hall
Arthur A. Kirchner	Victor E. Hallstone
E. R. Lambertson	Paul M. Hamilton
William H. Leake	John Thomas Hardesty
Robert G. Lehman	M. Coleman Harris
H. Clifford Loos	Thomas M. Hearn
J. Lafe Ludwig	Wybren Hiemstra
Douglas R. MacColl	Howard P. House
Wellesley P. Magan	John Hromadka
L. Duke Mahannah	Leland G. Hunnicutt
Russell W. Mapes	Willis L. Jacobus, Jr.

Delegates	*Alternates*
John B. Marr	Eugene J. Joergenson
Paul E. McMaster	Glen Ellis Jones
William R. Molony, Sr.	Milton R. Jones
James J. Morrow	Thomas R. Kidd
Carl L. Mulfinger	Theodore S. Kimball
M. L. Newkirk	George P. Landegger
Joseph P. O'Connor	Robert W. Langley
J. Norman O'Neill	Grant H. Lanphere
Frank W. Otto	Forrest E. Leffingwell
John R. Paxton	Thomas A. LeValley
Milton M. Portis	W. E. Macpherson
Aidan A. Raney	M. W. McDougall
James F. Regan	Edwin E. McNiel
E. T. Remmen	Robert W. Meals
Gordon L. Richardson	Arthur J. Mendenhall
Edward C. Rosenow, Jr.	John Everett Miracle
John C. Ruddock	Oliver M. Moore
Carl F. Rusche	Clarence H. Nelson
J. P. Sampson	Edward F. Nippert
Frank F. Schade	Maurice W. Nugent
Walter Scott	Ross V. Parks
J. Edward Short	Hubert J. Prichard
Ralph Varian Sloan	William F. Quinn
Ralph T. Smith	Paul A. Reichle
Elvin H. Stanton	Bruce E. Roesler
Justin J. Stein	Hollis E. Sides
Robert Leo Stern	Robert Simonds
Leonard Stovall	Gordon K. Smith
Clinton H. Thienes	William H. Snyder
Ewing L. Turner	Norman F. Sprague, Jr.
John O. Vaughn	Delbert L. Stokesbary
E. E. Wadsworth, Jr.	Packard Thurber, Jr.
Walter Wessels	Leon R. Walker
Allan B. Wilkinson	John W. Whitsett
Warren A. Wilson	Louis F. X. Wilhelm
Harold R. Witherbee	J. Walter Wilson
John H. Woodruff, Jr.	John M. Wright
Henry Marcus Young	William T. Zimmermann
Marin County (2)	
Warren Bostick	Alfred J. Schwarz
Howard Hammond	Leo L. Stanley
Mendocino-Lake County (1)	
J. E. Gardner	Thomas Hill
Merced County (1)	
George Pimentel	E. A. Jackson
Monterey County (3)	
S. Condit Glasgow	Frank Paul Cusenza
J. B. McCarthy	Howard C. Miles
James H. McPharlin	Allen Conrad Mitchell
Napa County (1)	
George I. Dawson	Walter H. Brignoli
Orange County (5)	
A. Norton Donaldson	Lester L. Blount
Charles E. Irvin	Harold F. Galbraith
G. Wendell Olson	Samuel Gendel
J. B. Price	Milton M. Maxwell
L. E. Wilson	Ralph E. White
Placer-Nevada-Sierra County (1)	
William M. Miller	Harry March
Riverside County (3)	
H. M. F. Behneman	Cecil Baisinger
Franklin B. Mead	Walter J. Crawford
Frederick A. Veitch	Norman H. Mellor
Sacramento County (5)	
Orrin Cook	George Chappell
Dave F. Dozier	Herbert Jenkins
A. M. Henderson, Jr.	Dan O. Kilroy
Dudley Saeltzer	Frank Lee
Ralph Teall	Edmund E. Simpson
San Benito County (1)	
Roswell L. Hull	John J. Haruff
San Bernardino County (5)	
Meredith G. Beaver	James C. Carmack
Carl M. Hadley	John H. Coughlin
J. Needham Martin	Frank C. Melone
E. L. Tisinger	Philip M. Savage, Jr.
Arthur E. Varden	Thomas I. Zirkle
San Diego County (10)	
Douglass H. Batten	Walter F. Carpenter
H. G. Holder	James I. Knott
Roger C. Isenhour	Joseph M. Maguire
Arthur A. Marlow	J. G. Omelvena
A. E. Moore	Roy A. Ouer
Willard H. Newman	James R. Phalen
Clarence E. Rees	James W. Ravenscroft
John M. Rumsey	Frank H. Robinson
Wesley S. Smith	W. T. Soldmann
Joseph W. Telford	Calvin L. Stewart

Delegates	*Alternates*
San Francisco County (28)	
Walter Beckh	Joseph Auerbach
William L. Bender	Donald M. Campbell
Walter Birnbaum	Robert C. Combs
Lois Brock	Lawrence R. Custer
William G. Burkhard	Gerald Feigen
Donald A. Carson	Claudius Y. Gates
Garnett Cheney	Gerald Gill
Martin W. Debenham	Francis T. Hodges
Anthony B. Diepenbrock	Clyde Horner
William T. Duggan	E. Donald Lastreto
Roberto Escamilla	Charles W. Leach
Henry L. Gardner	Harold H. Lindner
L. Henry Garland	Mary E. Mathes
Frank L. A. Gerbode	James J. McGinnis
Henry Gibbons, III	Theodore Paoli
Allen T. Hinman	Agnes G. Plate
Alson R. Kilgore	August Reich
Carleton Mathewson, Jr.	Wesley E. Scott
Joseph S. McGuinness	Samuel R. Sherman
Herbert C. Moffitt, Jr.	Abraham B. Sirbu
Mary B. Olney	Grace M. Talbott
Leon O. Parker	Emile D. Torre
Lowell A. Rantz	William W. Washburn
Francis Rochex	Forrest M. Willett
Robert A. Scarborough	A. Justin Williams
Donald R. Smith	Henry B. Woo
Francis A. Sooy	Paul S. Wyne
Huldah E. Thelander	Reuben Zumwalt
San Joaquin County (3)	
J. Frank Doughty	Louis P. Armanino
Jack Eccleston	Frank A. McGuire
Neill Johnson	George K. Wever
San Luis Obispo County (1)	
Robert O. Pearman	Richard T. Treadwell
San Mateo County (5)	
James S. Edwards	C. D. Benninghoven
Thomas E. Farthing	D. W. Boudett
Stuart Lindsay	Bradley C. Brownson
A. G. Miller	Logan Gray
Meade Mohun	R. F. McLaughlin
Santa Barbara County (3)	
J. Gary Campbell	Max Hammel
Lawrence M. Nelson	R. W. Lambuth
Alfred B. Wilcox	Douglas F. McDowell
Santa Clara County (7)	
C. Kelly Canelo	Deane Adams
Burt Davis	George B. Armanini
Thomas N. Foster	J. D. Lamon
Leon P. Fox	Thomas Lyon
J. B. Josephson	Ansten R. Ness
Leslie B. Magoon	J. Frederick Snyder
Paul V. Morton	Leo L. Wilson
Santa Cruz County (2)	
Luther Newhall	Ruth A. Frary
Samuel B. Randall	
Shasta County (1)	
Edward D. Ryan	George A. Martin
Siskiyou County (1)	
C. C. Dickinson	James B. McGuire
Solano County (2)	
Lionel Johnson	Bernard V. O'Donnell
F. Burton Jones	Felix J. Rossi, Jr.
Sonoma County (2)	
Donovan C. Oakleaf	William N. Makaroff
Horace F. Sharrocks	Roscoe L. Zieber
Stanislaus County (2)	
George S. Feher	Edward J. Denenholz
R. Stewart Hiatt	R. R. Radcliff
Tehama County (1)	
O. T. Wood	Harve Jourdan
Tulare County (2)	
J. H. Brady	C. H. Johnson
James E. Feldmayer	Wiley C. Zink
Ventura County (2)	
J. W. Moore	W. Cloyce Huff
A. A. Morrison	Gerald K. Ridge
Yolo County (1)	
Ray E. Nichols	Robert A. Burns
Yuba-Sutter-Colusa County (1)	
Stanley R. Parkinson	Walter J. Schmidt

House of Delegates Agenda

1951 Annual Session

Music Room, Biltmore Hotel

Speaker, L. A. ALESEN, *Los Angeles*
Vice-Speaker, DONALD CHARNOCK, *Los Angeles*
Secretary, ALBERT C. DANIELS, *San Francisco*

FIRST MEETING

Sunday, May 13, 1951, at 1:00 p.m.

ORDER OF BUSINESS

1. Call to order.
2. Report of Committee on Credentials, and Organization of the House of Delegates.
3. Roll call.
4. Announcement and approval of Reference Committees.
   (a) Committee on Credentials. (Delegates must register with the Committee.)
   (b) Reference Committee on the Reports of Officers, the Council and Standing and Special Committees. (Reference Committee No. 1.)
   (c) Reference Committee on Finance, to review the reports of the Secretary-Treasurer and the Executive Secretary and to study and make recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year. (Reference Committee No. 2.)
   (d) Reference Committee on Resolutions, Amendments to the Constitution and By-laws and New and Miscellaneous Business. (Reference Committee No. 3.)
   (e) Reference Committee on Executive Session, to consider business brought before the House of Delegates in Executive Session. (Reference Committee No. 4.)
5. Address by President—Donald Cass.
   Presentation of 50-Year Awards.
6. Miscellaneous announcements by the Speaker. (Stenographic service, to secure triplicate copies of resolutions, etc.)
7. Report of the Council—Sidney J. Shipman, chairman.
8. Report of the Trustees of the California Medical Association—Donald Cass, president.
9. Report of the Auditing Committee — H. Gordon MacLean, chairman.
10. Report of the Secretary—Albert C. Daniels.
11. Report of the Executive Secretary—John Hunton.
12. Report of the Editor—Dwight L. Wilbur.
13. Reports of District Councilors.
14. Reports of Councilors-at-Large.
15. Report of Legal Counsel—Peart, Baraty & Hassard.
16. Reports of Standing and Special Committees:
   A. Standing Committees:
   (a) Executive Committee—Donald D. Lum.
   (b) Committee on Associated Societies and Technical Groups—Robert A. Scarborough.
   (c) Committee on Audits—Donald D. Lum.
   (d) Committee on Health and Public Instruction—Orrin Cook.
   (e) Committee on History and Obituaries—Edmund T. Remmen.
   (f) Committee on Hospitals, Dispensaries, and Clinics—John B. Hamilton.
   (g) Committee on Industrial Practice—Raymond M. Wallerius.
   (h) Committee on Medical Defense—H. Clifford Loos.
   (i) Committee on Medical Economics—H. Gordon MacLean.
   (j) Committee on Medical Education and Medical Institutions—L. R. Chandler.
   (k) Committee on Organization and Membership—Carl L. Mulfinger.
   (l) Committee on Postgraduate Activities—John C. Ruddock.
   (m) Committee on Publications—George Dawson.
   (n) Committee on Public Policy and Legislation—Dwight H. Murray.
   (o) Committee on Scientific Work (Annual Session) —Albert C. Daniels.
   (p) Cancer Commission—Lyell C. Kinney.
   (q) Editorial Board—Dwight L. Wilbur.
   (r) Public Relations—John Hunton.
   B. Special Committees:
   (a) Delegates to the American Medical Association —E. Vincent Askey.
   (b) Physicians' Benevolence Committee — Axcel E. Anderson.
   (c) Advisory Planning Commission—John Hunton.
   (d) Blood Bank Commission—John Upton.
   (e) C.P.S. Liaison Committee—Donald Cass.
   (f) Committee on C.P.S. Administrative Changes—Orrin Cook.
   (g) Committee on Industrial Accident Commission Fee Schedule—Francis J. Cox.
   (h) Committee on Industrial Health — Christopher Leggo.
   (i) Committee on Rural Medical Service—Carroll B. Andrews.
18. Old and unfinished Business.
   (a) Constitution.
   (b) Constitutional Amendments.
19. New Business.

SECOND MEETING

Tuesday, May 15, at 1:00 p.m.

ORDER OF BUSINESS

1. Call to order.
2. Supplemental report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of place for the 1952 annual session.

5. Election of Officers:
   (a) President-Elect.
   (b) Speaker.
   (c) Vice-Speaker.
   (d) District Councilors (three-year term):*
      1. Second District—Jay J. Crane, Los Angeles (term expiring).
         Second District—Los Angeles County.
      2. Fifth District—Hartzell H. Ray, San Mateo (term expiring).
         Fifth District—Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz counties.
      3. Eighth District—Wayne E. Pollock, Sacramento (term expiring).
         Eighth District—Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba counties.

   (e) Councilors-at-Large (three-year terms):
   Francis E. West, San Diego (term expiring).
   Ivan C. Heron, San Francisco (term expiring).

   (f) Delegates to American Medical Association:
   Delegates and Alternates to the American Medical Association are elected for terms of two calendar years. The Delegates and Alternates to be elected at this meeting will serve for two calendar years ending December 31, 1953.

   Incumbents:
   (a) Robertson Ward (term expiring).
   (b) Sam J. McClendon (term expiring).
   (c) Eugene F. Hoffman (term expiring).
   (d) John W. Green (term expiring).
   (e) Lewis A. Alesen (term expiring).

   (g) Alternates to American Medical Association:
   Incumbents:
   (a) Anthony B. Diepenbrock (alternate to Robertson Ward).
   (b) Walter Cherry (alternate to Sam J. McClendon).
   (c) Frederic S. Ewens (alternate to Eugene F. Hoffman).
   (d) Frank A. MacDonald (alternate to John W. Green).
   (e) John Ball (alternate to Lewis A. Alesen).

6. Announcement by Secretary.
   Council's nominations of members of Standing Committees. (For approval by the House of Delegates.)
7. Reports of Reference Committees:
   (a) Report of Reference Committee No. 1 on Reports of Officers, the Council, and Standing and Special Committees.
   (b) Report of Reference Committee No. 2 on Reports of the Secretary-Treasurer and the Executive Secretary, on budget and dues.
   (c) Report of Reference Committee No. 3 on Resolutions, Amendments to the Constitution and By-Laws and New and Miscellaneous Business.
   (d) Report of Reference Committee No. 4 on business brought before the House of Delegates in Executive Session.
8. Unfinished Business.
9. New Business.
10. Presentation of Officers:
    President
    President-Elect
    Speaker
    Vice-Speaker
11. Presentation of Certificate to Retiring President—Donald Cass.
12. Approval of Minutes. (Committee to edit.)
13. Adjournment.

LEWIS A. ALESEN, *Speaker*
ALBERT C. DANIELS, *Secretary*

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Meeting of C.P.S. Administrative Members
May 13, 1951

AGENDA

1. Roll call.
2. Report of the President: Dr. J. Frank Doughty.
3. Question-and-Answer Period.
4. Report by Chairman of Fee Schedule Committee: Dr. R. G. Frey.
5. Announcement of Nominating Committee.
6. Announcement of Resolutions Committee.
7. Introduction of Resolutions.
8. Recess (48 hours).

SECOND MEETING

1. Roll call.
2. Consideration of report of Nominating Committee.
3. Consideration of resolutions and report of Resolution Committee.
4. New business.

**Procedure of nomination of District Councilors is outlined in paragraph 3 of Article VII, Section 1, of C.M.A. constitution, adopted on May 8, 1940:*
The nine district Councilors shall be elected as follows:
Prior to the time set for election of district Councilors, the delegates of each Councilor district for which a councilorship is about to become vacant, shall submit in writing to the Secretary-Treasurer the names of one or more nominees to fill the said vacancy.
The Secretary-Treasurer shall transmit the names of such nominee or nominees so submitted to him to the House of Delegates on or before the time set for the election.
A vote shall be taken by the House of Delegates upon the nominee or nominees so submitted and, in the event that only one nominee has been submitted, the House of Delegates may, by a majority vote, either elect or refuse to elect said nominee.
If the House of Delegates shall reject the sole nominee of the delegates from the councilorship district concerned, then said delegates must immediately thereafter submit an additional nominee or nominees and the House shall proceed to vote thereon; if there is but one nominee, the House may elect or reject.
If, after such time as the Speaker may allow, delegates within such councilor district fail to submit an additional nominee or nominees, the House of Delegates may then proceed to make nominations from the floor of the House and a vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship.
All nominees for district councilorships must be members in good standing, residing within the district in which the vacancy exists.

SCIENTIFIC SESSIONS

General Meetings

FIRST GENERAL MEETING

SUNDAY, MAY 13
10:00—Biltmore Theatre

Chairman: Donald Cass, M.D., Los Angeles

10:00—**Address of Welcome**—Richard O. Bullis, M.D., President, Los Angeles County Medical Association.

10:05—**Greetings from the Woman's Auxiliary**—Mrs. William R. Molony, Jr., President, Woman's Auxiliary to the California Medical Association.

10:10—**Address of the President**—Donald Cass, M.D., Los Angeles.

10:40—**The Non-Group Subscriber: A Blue Shield Problem**—Charles Gordon Heyd, M.D., New York, New York, by invitation.

11:10—**The Treatment of the Anemias** — Cyrus C. Sturgis, M.D., Ann Arbor, Michigan, by invitation.

11:35—**Some Recent Advances in Thoracic Surgery**—Herbert C. Maier, M.D., New York, New York, by invitation.

SECOND GENERAL MEETING

MONDAY, MAY 14
2:00—Biltmore Theatre

Chairmen: DeWitt K. Burnham, M.D., San Francisco; Frank Gerbode, San Francisco

2:00—**Some Recently Recognized Bone Lesions in Infants and Children**—John B. Caffey, M.D., New York, New York, by invitation.

2:30—**Observations on Pain** — Macdonald Critchley, M.D., F.R.C.P., London, by invitation.

3:00—**Question and Answer Period.**

Clinical-Pathological Conference

3:15—**Case No. 1** — Pathologist H. Russell Fisher, M.D., Los Angeles. Clinician Cyrus C. Sturgis, M.D., Ann Arbor, Michigan, by invitation.

4:00—**Case No. 2** — Pathologist Leo Kaplan, M.D., Los Angeles, by invitation. Surgeon Herbert C. Maier, M.D., New York, New York, by invitation.

Section Meetings

GENERAL MEDICINE

DeWitt K. Burnham, M.D., San Francisco, *Chairman*
Edgar Frank Mauer, M.D., Los Angeles, *Secretary*
James Malcolm Stratton, M.D., Oakland, *Assistant Secretary*

DEWITT K. BURNHAM
Chairman

EDGAR FRANK MAUER
Secretary

MONDAY, MAY 14

9:00—Biltmore Theatre

Joint Meeting with Section on General Surgery

Symposium

Diseases of the Lung

9:00—**Diagnosis and Treatment of Carcinoma of the Lung:**

Primary Carcinoma of the Lung—Herbert C. Maier, M.D., New York, by invitation.

Diagnostic Problems of Lung Cancer—Seymour M. Farber, M.D., San Francisco.

9:30—**Management of Pulmonary Suppuration:**

Antibiotic Therapy of Pulmonary Suppuration—William Hewitt, M.D., Los Angeles, by invitation.

The Management of Lung Abscess—Francis X. Byron, M.D., Los Angeles, by invitation.

10:00—**Pulmonary Tuberculosis:**

Selection of Patients with Tuberculosis for Pulmonary Surgery—Reginald Smart, M.D., Los Angeles.

Pulmonary Resection in Tuberculosis—David J. Dugan, M.D., Oakland.

10:30—**Coccidioidomycosis:**

The Diagnosis of Pulmonary Coccidioidal Infection—Charles E. Smith, M.D., Berkeley.

Surgical Treatment of Pulmonary Coccidioidal Infection—Bert H. Cotton, Beverly Hills.

11:00—**Panel Discussion**—Members are invited to submit questions in writing. Herbert C. Maier, M.D., New York, by invitation, Moderator; Frank Gerbode, M.D., San Francisco, Surgery; H. Corwin Hinshaw, M.D., San Francisco, Medicine; Marcy L. Sussman, M.D., Phoenix, by invitation, Radiology; Charles E. Smith, M.D., Berkeley, Medicine and Public Health.

TUESDAY, MAY 15

9:30—Burdette Hall, Baptist Church, Philharmonic Building

Joint Meeting with Section on General Practice

Symposium

Cortisone and ACTH

9:30—**Experiences with Oral Cortisone**—Ephraim P. Engleman, M.D., San Francisco.

9:50—**ACTH and Cortisone: Experience with Private Patients**—Gordon R. Lamb, M.D., Laurance Kinsell, M.D., and Fletcher B. Taylor, M.D., Oakland.

10:10—**Experience with Cortisone and ACTH in a Private Clinic**—Marcus A. Krupp, M.D.; Milton Saier, M.D.; Frances Keddie, M.D.; Ralph Tanner, M.D., and A. M. Snell, M.D., Palo Alto.

10:30—**The Results of Prolonged Use of Cortisone in Rheumatoid Arthritis and Other Rheumatic Diseases**—Nathan E. Headley, M.D., Los Angeles.

10:50—**Panel Discussion—Practical Application of ACTH and Cortisone:** Edwin L. Bruck, M.D., San Francisco, Moderator; Paul Starr, M.D., Pasadena; Laurance W. Kinsell, M.D., Oakland; Edward Boland, M.D., Los Angeles; John S. Lawrence, M.D., Los Angeles, and Marcus A. Krupp, M.D., Palo Alto.

* * *

11:40—**Some Recent Advances in Our Methods of Treating Thyroid Disorders**—Cyrus C. Sturgis, M.D., Ann Arbor, Michigan, by invitation.

WEDNESDAY, MAY 16

9:30—Burdette Hall, Baptist Church, Philharmonic Building

9:30—**End Results for Gastric Cancer in Los Angeles**—Lewis E. Guiss, M.D., Los Angeles.

10:00—**The Clinical Importance of Generalized Sarcoidosis**—Walter Beckh, M.D., and William F. Weeden, M.D., San Francisco.

10:15—**Subacute Thyroiditis**—John O. Westwater, M.D., Los Angeles.

10:30—**Business Meeting and Election of Officers.**

10:40—**The Diagnosis of the Hemolytic Anemias**—Edward R. Evans, M.D., Pasadena.

10:55—**The Management of Purpura Hemorrhagica, Based on a Review of 48 Cases at a Private Hospital**—Brigham Bergstrom, M.D., Beverly Hills.

11:10—**Protean Manifestations of Infectious Mononucleosis**—Herbert C. Moffitt, Jr., M.D., San Francisco.

11:25—**The Nature and Treatment of Leukemia and Allied Conditions**—Cyrus C. Sturgis, M.D., Ann Arbor, Michigan, by invitation.

11:55—**Annual Meeting**—California Society of Internal Medicine.

WEDNESDAY, MAY 16

2:00—Burdette Hall, Baptist Church, Philharmonic Building

2:00—**Chairman's Address: N.P.H. Insulin**—DeWitt Burnham, M.D., San Francisco.

2:15—**Intravenous Use of Pituitrin in the Control of Massive Pulmonary Hemorrhage**—Harold G. Trimble, M.D., and James Robert Wood, M.D., Oakland.

2:25—**Vitamin U Therapy of Peptic Ulcer**—Garnett Cheney, M.D., San Francisco.

2:45—**Less Commonly Recognized Clinical Features of Amebiasis**—Mervin J. Goldman, M.D., Oakland.

3:00—**Diphtheria: The Present Day Problem**—Henry Brainerd, M.D., and Henry Bruyn, M.D., San Francisco.

3:20—**Western Equine and St. Louis Encephalitis in California**—Edwin H. Lennette, M.D., Ph.D., Berkeley, and William Allen Longshore, M.D., Berkeley, by invitation.

3:40—**Needle Biopsy of the Liver**—William E. Molle, M.D., Los Angeles, and Leo Kaplan, M.D., Los Angeles, by invitation.

3:55—**Volvulus of the Stomach**—Walter P. Martin, M.D., and Tom A. Kendig, M.D., Long Beach.

4:05—**The Use of Banthine in the Treatment of Digestive Disturbances**—Leonard M. Asher, M.D., Beverly Hills.

CALIFORNIA HEART ASSOCIATION

Annual Scientific Meeting

The Annual Scientific Meeting of the California Heart Association will be held Wednesday, May 16, 1:30 p.m. to 5:00 p.m., in the Music Room of the Biltmore Hotel.

GENERAL SURGERY

Frank Gerbode, M.D., San Francisco, *Chairman*
William P. Longmire, Jr., M.D., Los Angeles, *Secretary*
H. J. McCorkle, M.D., San Francisco, *Assistant Secretary*

FRANK GERBODE
Chairman

WILLIAM P. LONGMIRE, JR.
Secretary

MONDAY, MAY 14

9:00—Biltmore Theatre

Joint Meeting with Section on General Medicine

For Program, see Section on General Medicine

TUESDAY, MAY 15

9:30—Auditorium, Southern California Edison Building

9:30—Chairman's Address: Surgery of Acquired Heart Disease—Frank Gerbode, M.D., San Francisco.

Discussion.

9:50—Treatment of Tumors of the Esophagus—Herbert C. Maier, M.D., New York, by invitation.

Discussion.

10:10—Planned Resection of the Regional Lymph Nodes in Pneumonectomy for Bronchiogenic Carcinoma—Joseph Weinberg, M.D., Long Beach.

Discussion.

10:30—The Surgical Treatment of Mitral Stenosis—William H. Muller, Jr., Los Angeles, by invitation.

Discussion.

10:50—Newer Concepts of Surgical Anatomy of the Lung—H. H. Lindner, M.D., and John B. deC. Saunders, M.D., San Francisco.

Discussion.

11:10—The Conservation of Tissue and Function in Pulmonary Resections by the Correct Use of Segmental Resection: Technique of the Anatomical Separation of Segments—Beatty H. Ramsay, M.D., Los Angeles, by invitation.

Discussion.

11:30—Treatment of Arterial Hypertension by Subtotal Thoracolumbar Sympathectomy—Theodore B. Massell, M.D., Los Angeles.

Discussion.

11:50—Review of Korean Thoracic Injuries at the U. S. Naval Hospital, Oakland—Captain Everett H. Dickinson (MC), USN, by invitation; Commander Emanuel Rollins (MC), USN, by invitation, and Gerald L. Crenshaw, M.D., Oakland.

Discussion.

WEDNESDAY, MAY 16

9:30—Auditorium, Southern California Edison Building

9:30—Observations on Aortic Embolism with Report of 13 Additional Cases—Allan B. Wilkinson, M.D., Glendale.

Discussion.

9:50—Struma Lymphomatosa—Charles T. Sturgeon, M.D., Los Angeles, and Kenneth W. Blake, M.D., Beverly Hills.

Discussion.

10:10—Metastatic Carcinoma of the Thyroid as an Initial Manifestation of the Disease—O. G. Davies, M.D.; Stuart Lindsay, M.D., and H. H. Searls, M.D., San Francisco.

Discussion.

10:30—**The Surgical Treatment of Massive Hemorrhage from Peptic Ulcer**—James M. Marshall, M.D., Pasadena.

Discussion.

10:50—**Resection of the Axillary Vein During Radical Mastectomy**—John M. Kenney, M.D., and R. L. Zieber, M.D., Santa Rosa.

Discussion.

11:10—**Duodenal Fistulas Following Gastrectomy**—R. Bruce Henley, M.D., Oakland.

Discussion.

11:30—**A Study of Small Bowel Tumors (Special Emphasis on Clinical Aspects)**—E. J. Joergenson, M.D., Glendale, and Laurel H. Weibel, M.D., Los Angeles, by invitation.

Discussion.

11:50—**Non-Rotation of the Midgut**—J. Norton Nichols, M.D., Los Angeles.

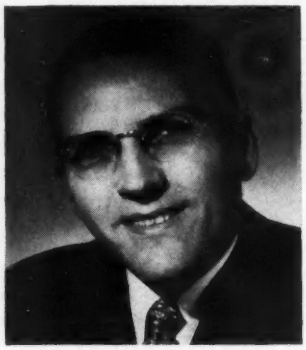
Discussion.

12:10—**Carcinoma of the Ampulla of Vater—Three 10-Year Cases**—Louis C. Bennett, Los Angeles.

Discussion.

GENERAL PRACTICE

James E. Reeves, M.D., San Diego, *Chairman*
John B. Long, M.D., Sacramento, *Secretary*
Merlin L. Newkirk, M.D., South Gate, *Assistant Secretary*



JAMES E. REEVES
Chairman

JOHN B. LONG
Secretary

MONDAY, MAY 14

9:30—Music Room, Biltmore Hotel

9:30—**Prolonged Labor**—Philip H. Arnot, M.D., San Francisco.

9:55—**The Rh Factor in Rural Practice**—James L. Dennis, M.D., Merced.

Discussion by pediatrician—Henry Bruyn, M.D., San Francisco.

Discussion by obstetrician — Philip Arnot, M.D., San Francisco.

10:30—**Treatment of Closed Head Injuries**—Lester B. Lawrence, M.D., Oakland.

10:55—**Anal Infections Encountered in General Practice**—Malcolm R. Hill, M.D., Los Angeles.

11:20—**Chairman's Address: The General Practitioner and the Coroner's Office**—James E. Reeves, M.D., San Diego.

11:40—**Business Meeting and Election of Officers.**

TUESDAY, MAY 15

9:30—Burdette Hall, Baptist Church, Philharmonic Building

Joint Meeting with Section on General Medicine

For Program, see Section on General Medicine

WEDNESDAY, MAY 16

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on Urology

9:30—**Enuresis**—Donald A. Charnock, M.D., Los Angeles.

Discussion by pediatrician—Harry Dietrich, M.D., Los Angeles.

10:00—**Common Diseases of the Female Urethra**—Carl E. Burkland, M.D., Sacramento.

Discussion by Ector LeDuc, M.D., San Diego.

10:30—**Mental Fixations and Phobias Affecting the Urogenital System**—Alfred Auerback, M.D., San Francisco.

Discussion by Donald R. Smith, M.D., San Francisco.

11:00—**Coordinating Patient Care between Urologist and General Practitioner**—Bernard B. Gadwood, M.D., Richmond.

Discussion by R. T. Bergman, M.D., Los Angeles.

11:30—**Modern Use of Urinary Antiseptics**—Frank Hinman, Jr., M.D., San Francisco.

Discussion by A. J. Scholl, M.D., Los Angeles.

ALLERGY

Frank G. Crandall, Jr., M.D., Los Angeles, *Chairman*
Samuel H. Hurwitz, M.D., San Francisco, *Vice-Chairman*
M. Coleman Harris, M.D., Beverly Hills, *Secretary*

FRANK G. CRANDALL, JR.
Chairman

M. COLEMAN HARRIS
Secretary

WEDNESDAY, MAY 16

9:30—Conference Room 4, Biltmore Hotel

9:30—**Chairman's Address: Public Relations in the Practice of Allergy**—Frank G. Crandall, Jr., M.D., Los Angeles.

10:00—**Pulmonary Emphysema and its Relation to Respiratory Allergy** — Marvin Harris, M.D., Los Angeles.

Discussion by Reginald Smart, M.D., Los Angeles.

10:30—**Evaluation of a New Method of Dust Control** —M. Coleman Harris, M.D., and Norman Shure, M.D., Beverly Hills.

Discussion by Samuel H. Hurwitz, M.D., San Francisco.

11:00—**Practical Aspects of Allergy in Ophthalmology**—Maurice Nugent, M.D., Los Angeles.

Discussion by A. Ray Irvine, M.D., Los Angeles.

11:30—**Asthmatic Bronchitis**—Dar D. Stofer, M.D., Monterey.

Discussion by George Piness, M.D., Los Angeles.

WEDNESDAY, MAY 16

2:00—Conference Room 4, Biltmore Hotel

2:00—**Allergy, Atopy and Anergy: A Nosologic Quandary** — Hyman Miller, M.D., Beverly Hills.

Discussion by William Hewitt, M.D., Los Angeles.

2:30—**Asthma and Cardiac Dyspnea: A Differential Diagnosis**—Frank Perlman, M.D., Portland, Oregon, by invitation.

3:30—**Basic Tissue Reactions in Allergic Injury**—James F. Rinehart, M.D., San Francisco.

Discussion by M. Coleman Harris, M.D., Beverly Hills.

4:00—**Oral and Intravenous Use of Pronestyl in Allergic Disease** — Henry T. Friedman, M.D., Beverly Hills.

Discussion by Jerome Sievers, M.D., Los Angeles.

4:30—**New Modified Epinephrine Solutions as Therapeutic Aids**—Roy A. Ouer, M.D., San Diego.

Discussion by Lyle Bacon, M.D., Los Angeles.

ANESTHESIOLOGY

Douglass H. Batten, M.D., San Diego, *Chairman*
Fenimore E. Davis, M.D., Oakland, *Secretary*
Nevin H. Rupp, M.D., Los Angeles, *Assistant Secretary*

DOUGLASS H. BATTEN
Chairman

FENIMORE E. DAVIS
Secretary

MONDAY, MAY 14

9:30—Conference Room 5, Biltmore Hotel

9:30—**Intravenous Procaine, Present Concepts and Techniques**—Robert W. Churchill, M.D., San Francisco.
Discussion.

10:00—**Resuscitation of the Newborn**—Lieutenant Frank M. Thornberg (MC), USN, Oakland.
Discussion.

10:30—**Oxygen Therapy**—John B. Dillon, M.D., Los Angeles.
Discussion.

11:00—**Pre- and Postoperative Medication in Relation to Anesthesia**—D. A. Roman, M.D., and Marvin Darsie, M.D., Los Angeles.
Discussion.

MONDAY, MAY 14

2:00—Conference Room 5, Biltmore Hotel

2:00—**Procedures in Cardiac Arrest**—William H. Cassels, M.D., San Mateo.
Discussion.

2:30—**Present Status of Endotracheal Anesthesia in Children**—Woodrow Lomas, M.D., San Francisco.
Discussion.

3:00—**Do's and Don'ts of Spinal Anesthesia**—Bruce M. Anderson, M.D., Oakland.
Discussion.

3:30—**New Drugs in Anesthesia**—Richard W. Poytress, M.D., San Jose.
Discussion.

DERMATOLOGY AND SYPHILOLOGY

Arne E. Ingels, M.D., San Francisco, *Chairman*
Richard O. Pfaff, M.D., San Jose, *Secretary*
Kenneth L. Stout, M.D., Beverly Hills, *Assistant Secretary*

ARNE E. INGELS
Chairman

RICHARD O. PFAFF
Secretary

MONDAY, MAY 14

9:30—Burdette Hall, Baptist Church, Philharmonic Building

9:30—The Laboratory in Relation to ACTH and Cortisone Therapy—Robert L. Dennis, M.D., San Jose.

9:50—Evaluation of ACTH in Diseases of Skin—Eugene Farber, M.D., San Francisco.

10:10—Present Status of Cortisone in Dermatology—Ben Newman, M.D., Los Angeles.

Discussion of Preceding Papers.

10:40—Efficiency of Bismuth Lanolin Putty in Shielding of Skin Against Roentgen Radiation, with Additional Suggestions in Technique—J. Walter Wilson, M.D., Los Angeles.

Discussion.

11:10—Riboflavin in Psoriasis—A New Concept in Treatment—Merlin T-R. Maynard, M.D., San Jose.

Discussion.

11:40—Estrogen Therapy in Acne—Contraindications—Sheldon A. Payne, M.D., Los Angeles.

Discussion.

MONDAY, MAY 14

2:00—Burdette Hall, Baptist Church, Philharmonic Building

2:00—Chairman's Address: Present Status of Treatment of Tuberculosis of Skin—Arne Ingels, M.D., San Francisco.

2:20—Treatment of Impetigo with Sulfonamide Urea Powder—Rees B. Rees, Jr., M.D., Edwin M. Hamlin, M.D., San Francisco, and James P. McGinley, M.D., San Francisco, by invitation.

Discussion.

2:50—Trichophyton Tonsurans (Crateriforme) Infection of the Scalp — Harold Price, M.D., North Hollywood.

Discussion.

3:20—Dissemination of Chronic Discoid Lupus Erythematosus—Edward J. Ringrose, M.D., Berkeley.

3:50—Skin Disease in Tattoos—Glenn Lubeck, M.D., Oakland, by invitation.

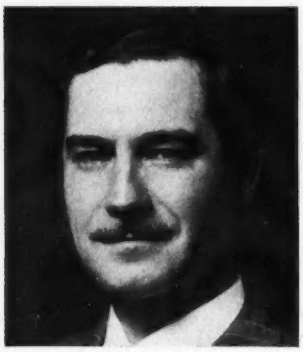
Discussion.

4:20—Business Meeting and Election of Officers.

EYE, EAR, NOSE AND THROAT

George F. Keiper, Jr., M.D., Visalia, *Chairman*
Maurice W. Nugent, M.D., Los Angeles, *Secretary*
Robert C. McNaught, M.D., San Francisco, *Assistant Secretary*

GEORGE F. KEIPER, JR.
Chairman



MAURICE W. NUGENT
Secretary

MONDAY, MAY 14

9:30—Conference Room 8, Biltmore Hotel

9:30—**The Problem of the Deformities of the Nasal Septum in Relation to Rhinoplastic Surgery**—Manuel R. Wexler, M.D., Los Angeles.

Discussion by Ernest R. V. Anderson, M.D., Los Angeles.

10:00—**Proper Use of Antibiotics in the Treatment of Acute Otitis Media**—Miriam H. Rutherford, M.D., Oakland.

Discussion by Victor Goodhill, M.D., Los Angeles.

10:30—**Scleroma** — Edward H. Crane, M.D., Inglewood.

Discussion by Russell Fisher, M.D., Los Angeles.

11:00—**Surgical Approach to Tumors of the Nasopharynx**—Francis Sooy, M.D., San Francisco.

Discussion by Samuel Perzik, M.D., Beverly Hills.

11:30—**A Plastic Procedure on the Fossa at the Time of Tonsillectomy** — Emery Leivers, M.D., Woodland.

Discussion by Leland Hunnicutt, M.D., Pasadena.

MONDAY, MAY 14

2:00—Conference Room 8, Biltmore Hotel

2:00—**Intranasal Diathermy Operation of the Tear Sac**—Paul H. Reed, M.D., Los Angeles.

Discussion by Eugene Christensen, M.D., Los Angeles.

2:30—**Hyperphoria Induced by Trial Lenses**—Robert J. Schillinger, M.D., Los Angeles.

Discussion by Sidney Brownsberger, M.D., Los Angeles.

3:00—**Use of Free Grafts in Correction of Recurrent Pterygia, Pseudopterygia and Symblepharon**—Deane Hartman, M.D., Los Angeles.

Discussion by Orwyn Ellis, M.D., Los Angeles.

3:30—**Intermission.**

3:40—**Business Meeting.**

3:50—**Sturge-Weber Syndrome**—Levon K. Garron, M.D., Oakland.

Discussion by A. Ray Irvine, Jr., M.D., Beverly Hills.

4:20—**Precancerous Melanosis**—Crowell Beard, M.D., San Jose, and Michael J. Hogan, M.D., San Francisco.

Discussion by Phillips Thygeson, M.D., San Jose.

INDUSTRIAL MEDICINE AND SURGERY

Robert K. Gustafson, M.D., Pasadena, *Chairman*
Herbert C. Sanderson, M.D., Sacramento, *Secretary*
Orris R. Myers, M.D., Eureka, *Assistant Secretary*

ROBERT K. GUSTAFSON
Chairman

HERBERT C. SANDERSON
Secretary

MONDAY, MAY 14

9:30—Conference Room 7, Biltmore Hotel

9:30—**Results of Treatment of Intervertebral Disc Protrusion with Special Reference to the Anterior Extraperitoneal Route**—Paul H. Harmon, M.D., Oakland.

Discussion by Paul E. McMaster, M.D., Los Angeles.

10:00—**Hand Dermatitis in Industry** — Norman Epstein, M.D., and James R. Allen, M.D., San Francisco.

Discussion by William Harding, M.D., Sacramento.

10:30—**Evaluation of Industrial Disability**—Packard Thurber, M.D., Los Angeles, and Subcommittee for the "Standardization of Joint Measurements in Industrial Injury Cases," of the California Medical Association, Packard Thurber, M.D., Chairman.

Discussion by Fred P. Schafer, M.D., R. W. Stellar, M.D., and by invitation, Mr. John J. Batistich, Los Angeles.

11:00—**Attitudes Toward the Doubtful Compensation Claim**—Christopher Leggo, M.D., Crockett.

Discussion by R. T. Johnstone, M.D., Los Angeles.

11:30—**Elbow Injuries**—Melvin T. Hurley, M.D., Richmond.

Discussion by John Wright, M.D., Pasadena, and Francis J. Cox, M.D., San Francisco.

12:00—**Business Meeting—Election of Officers.**

MONDAY, MAY 14

2:00—Conference Room 9, Biltmore Hotel

2:00—**Bone Repair in Rats with Multiple Fractures** —Marshall R. Urist, M.D., Los Angeles.

Discussion by Vernon Luck, M.D., Los Angeles.

2:30—**Comminuted Fractures of the Acetabulum with Central Dislocation of the Femur** — Arthur Holstein, M.D., and Gwilym B. Lewis, M.D., Berkeley.

Discussion by F. Harold Downing, M.D., Fresno.

3:00—**Malingering After Industrial Injuries**—Walter Z. Baro, M.D., Los Angeles.

Discussion by DeWard Jones, M.D., Los Angeles.

3:30—**My Aching Back** — Rodney F. Atsatt, M.D., Santa Barbara.

Discussion by Merrill Mensor, M.D., San Francisco.

4:00—**Anoxia in the Acute Head Injury** — John E. Adams, M.D., San Francisco.

Discussion by Howard Naffziger, M.D., San Francisco, and A. A. Raney, M.D., Los Angeles.

OBSTETRICS AND GYNECOLOGY

Leon Krohn, M.D., Los Angeles, *Chairman*
Woodburn K. Lamb, M.D., Berkeley, *Vice-Chairman*
Hervey K. Graham, M.D., San Diego, *Secretary*

LEON KROHN
Chairman

HERVEY K. GRAHAM
Secretary

TUESDAY, MAY 15

9:30—Chapel, Baptist Church, Philharmonic Building

9:30—Report on Therapeutic Abortions in California Keith P. Russell, M.D., Chairman, Committee on the Abortion Problem in California, Los Angeles.

Discussion by Purvis L. Martin, M.D., San Diego, and Donald W. deCarle, M.D., San Francisco.

10:00—Coordinating the Services of the Obstetrician and General Practitioner in an Obstetrical Department—Blake H. Watson, M.D., Los Angeles.

Discussion by Rodney H. Snow, M.D., Santa Monica, and Robert H. Fagan, M.D., Beverly Hills.

10:30—Emergencies in Obstetrics and Gynecology—Charles M. Malone, M.D., Los Angeles.

Discussion by Hobart Kelly, M.D., Riverside, and Ralph H. Walker, M.D., Los Angeles.

11:00—Primary Postpartum Hemorrhage—George F. Melody, M.D., San Francisco.

Discussion by Donald W. deCarle, M.D., San Francisco, and Donald G. Tollefson, M.D., Los Angeles.

WEDNESDAY, MAY 16

9:30—Chapel, Baptist Church, Philharmonic Building

9:30—Business Meeting.

9:50—Culdoscopy—Stanley T. Lee, M.D., Fresno.

Discussion by William B. McGee, M.D., San Diego, and Paula Horn, M.D., Los Angeles.

10:20—Chairman's Address—Leon Krohn, M.D., Los Angeles.

10:40—Intracavitary Injection of Radioactive Isotopes for Inoperable Malignancy—Henry L. Jaffe, M.D., Los Angeles.

Discussion by Samuel Perzik, M.D., Beverly Hills.

11:10—The Management of Carcinoma of the Uterine Cervix—Ian Macdonald, M.D., Los Angeles.

Discussion by Bernard J. Hanley, M.D., Los Angeles, and Erle Henriksen, M.D., Los Angeles.

PATHOLOGY AND BACTERIOLOGY

Warren Bostick, M.D., San Francisco, *Chairman*
Leon John Tragerman, M.D., Los Angeles, *Secretary*
Charles M. Blumenfeld, M.D., Sacramento, *Assistant Secretary*

WARREN BOSTICK
Chairman

LEON JOHN TRAGERMAN
Secretary

MONDAY, MAY 14

9:30—Chapel, Baptist Church, Philharmonic Building

9:30—**Pulmonary Endarteritis Associated with Cor Pulmonale, Simulating Congenital Heart Disease**—J. D. Kirshbaum, M.D., San Bernardino.
Discussion.

9:50—**Tumors in Childhood, Statistical Review**—Ralph E. Knutti, M.D., Los Angeles.
Discussion.

10:30—**Streptomycin Sensitivity of Tubercle Bacilli Obtained from Surgically Resected Lungs**—Perry J. Melnick, M.D., and Alfred S. Goldman, M.D., Los Angeles, and Eric Stern, M.D., Duarte, by invitation.
Discussion.

11:00—**The Rare Tumors of the Testis**—Nathan B. Friedman, M.D., Los Angeles.
Discussion by Harry Goldblatt, M.D., and Alvin G. Foord, M.D., Pasadena.

11:30—**Exfoliative Cytology of Carcinoma, Los Angeles County Hospital**—H. Schuyler Aijian, M.D., by invitation, and Bernadette Browell, by invitation, Los Angeles.
Discussion.

MONDAY, MAY 14

2:00—Chapel, Baptist Church, Philharmonic Building

2:00—**Primary Systemic Amyloidosis With Predominant Pulmonary Involvement**—Meyer Zeiler, M.D., Los Angeles.
Discussion.

2:20—**Chairman's Address**—Warren L. Bostick, M.D., San Francisco.
Discussion.

3:00—**The Serologic Diagnosis of Viral and Rickettsial Diseases**—Charles M. Carpenter, M.D., Los Angeles.
Discussion.

3:40—**Mediterranean Anemia as a Common Diagnostic Problem**—Paul G. Hattersley, M.D., Sacramento.
Discussion.

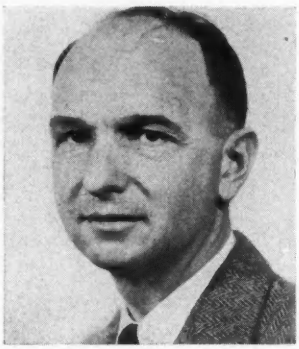
4:00—**Some Problems Encountered in Blood Banks and Transfusions**—David Singman, M.D., Berkeley, and Charles Smiley, B.A., Berkeley, by invitation.
Discussion.

4:20—**Business Meeting—Election of Officers.**

4:30—**Recess**—Annual Meeting, California Society of Pathologists.

PEDIATRICS

Richard D. Cutter, M.D., Palo Alto, *Chairman*
Joseph W. St. Geme, M.D., Los Angeles, *Secretary*
Alvin H. Jacobs, M.D., San Francisco, *Assistant Secretary*



RICHARD D. CUTTER
Chairman

JOSEPH W. ST. GEME
Secretary

TUESDAY, MAY 15

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on Radiology

9:30—Radiologic Aspects of Chest Diseases in Children—John Caffey, M.D., by invitation, New York, N. Y.

10:30—Megacolon—Rolla G. Karshner, M.D., Los Angeles, and Emma Elizabeth Leon, M.D., by invitation, Los Angeles.

11:00—Early Roentgen Diagnosis of Congenital Hip Disease—Ralph B. Miller, M.D., Los Angeles.

11:30—Radiation Nephritis — Anthony R. Camero, M.D., and James H. Cremin, M.D., Los Angeles.

WEDNESDAY, MAY 16

9:30—Conference Room 8, Biltmore Hotel

9:30—Mediterranean Anemia—Henry Silver, M.D., San Francisco.

10:00—The Problem of the Mentally Retarded Child —Peter Cohen, M.D., San Francisco.

10:30—Acute Respiratory Diseases in Children—John Milton Adams, M.D., by invitation, Los Angeles.

11:00—Evaluation of Activity of Rheumatic Fever—John Anderson, M.D., San Francisco.

11:30—Business Meeting.

WEDNESDAY, MAY 16

2:00—Conference Room 8, Biltmore Hotel

Panel Discussion

What's New in Pediatrics

Moderator: Donald C. Shelby, M.D., Los Angeles

2:00—Prophylaxis of Eyes of Newborn—Wendell M. Redfern, M.D., Glendale.

2:20—Pros and Cons of Routine Circumcision — Deron Hovsepian, M.D., by invitation, Pasadena.

2:40—Forefoot Varus in Infants—Udell M. Gessel, M.D., Los Angeles.

3:00—Use of ACTH and Cortisone in Children—Alfred Knudson, M.D., by invitation, Los Angeles.

3:20—Treatment of Anemia—Phillip Sturgeon, M.D., by invitation, Los Angeles.

3:40—Treatment of Epilepsy—Gaston J. Baus, M.D., Glendale.

PSYCHIATRY AND NEUROLOGY

G. Creswell Burns, M.D., Compton, *Chairman*
O. W. Jones, Jr., M.D., San Francisco, *Secretary*

G. CRESWELL BURNS
Chairman

O. W. JONES, JR.
Secretary

MONDAY, MAY 14

9:30—Conference Room 9, Biltmore Hotel

9:30—**Chairman's Address: Recognition of Mental Illness**—G. Creswell Burns, M.D., Compton.
Discussion.

10:00—**The Ultimate Residuals of Antenatal and Neonatal Asphyxia**—Cyril B. Courville, M.D., Los Angeles.
Discussion.

10:30—**Therapeutic Value of Unilateral Lobotomy in Psychoses**—Alexander Simon, M.D., by invitation, Lester Margolis, M.D., Karl Bowman, M.D., John E. Adams, M.D., San Francisco.
Discussion.

11:00—**Progressive Adhesive Arachnoiditis Following Spinal Anesthesia** — Ward W. Woods, M.D., Roland G. Franklin, M.D., San Diego.
Discussion.

11:30—**Some Viewpoints on Child Psychiatry**—Forrest N. Anderson, M.D., Van Nuys.
Discussion.

TUESDAY, MAY 15

9:30—Conference Room 1, Biltmore Hotel

9:30—**Business Meeting and Election of Officers.**

9:40—**Recurring Utterances in Aphasic Patients**—Macdonald Critchley, M.D., F.R.C.P., London, by invitation.
Discussion.

10:20—**Apoplectic Stroke in the Young Adult**—Edwin Boldrey, M.D., San Francisco.
Discussion.

10:50—**Intracranial Vascular Lesions** — C. Hunter Shelden, M.D., Pasadena.
Discussion.

11:20—**Some Relationships Between Heart Attacks and Paralytic Strokes** — Clarence W. Olsen, M.D., Beverly Hills.
Discussion.

PUBLIC HEALTH

Martin Mills, M.D., Richmond, *Chairman*
J. B. Askew, M.D., San Diego, *Secretary*
John R. Philp, M.D., Chico, *Assistant Secretary*

MARTIN MILLS
Chairman

J. B. ASKEW
Secretary

TUESDAY, MAY 15

9:30—Conference Room 5, Biltmore Hotel

9:30—Significance of Tuberculosis in the Itinerant Mexican Laborer — C. R. Kroeger, M.D., El Centro.

Discussion.

10:00—A Study of Anemia in Mexican Mothers—Their Infants and Their Siblings—Emma H. B. Wharton, M.D., and Edward Lee Russell, M.D., Santa Ana.

Discussion.

10:30—Recess.

10:45—Mental Health in a Chest Clinic — Herbert Bauer, M.D., Sacramento.

Discussion by V. J. Wyborney, M.D., San Diego.

11:15—A 28-Year Review of Tetanus Trends in Los Angeles County—Mary B. Dale, M.D., Roy O. Gilbert, M.D., Los Angeles, and James T. Oliver, B.S., by invitation, Los Angeles.

Discussion by William P. Frank, M.D., Los Angeles.

WEDNESDAY, MAY 16

9:30—Conference Room 5, Biltmore Hotel

9:30—A Ten-Year Study of Encephalitis in Kern County—William C. Buss, M.D., Bakersfield.

Discussion by Edwin H. Lennette, M.D., Berkeley.

10:00—The Changing Epidemiology of Typhoid Fever in California—Rosemary Brunetti, M.D., Arthur C. Hollister, Jr., M.D., Berkeley, and Florence Ames, R.N., by invitation, Berkeley.

Discussion.

10:30—Recess.

10:45—The Organization and Operation of a Study of Diarrheal Disease in Fresno County—William F. Stein, M.D., Fresno.

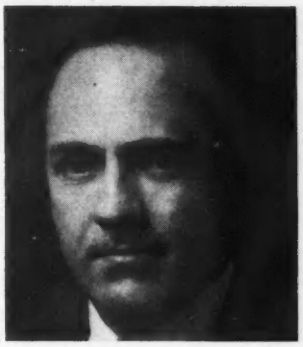
Discussion by James Watt, M.D., Atlanta, Georgia.

11:30—Business Meeting and Election of Officers.

RADIOLOGY

Sydney F. Thomas, M.D., Palo Alto, *Chairman*
Harold P. Tompkins, M.D., Los Angeles, *Secretary*
Robert K. Arbuckle, M.D., Oakland, *Assistant Secretary*

SYDNEY F. THOMAS
Chairman



HAROLD P. TOMPKINS
Secretary

MONDAY, MAY 14

9:30—Conference Room 2, Biltmore Hotel

9:30—**The Treatment of Metastatic Breast Cancer in Bone**—M. A. Sisson, M.D., and L. H. Garland, M.D., San Francisco.

10:00—**Radiation Therapy in Breast Cancer**—A Preliminary Report on the Application of McWhirter's Technique—Colonel Elmer A. Lodmell (MC), USA, San Francisco, by invitation.

Discussion by L. H. Garland, M.D., San Francisco.

10:30—**Recess: Annual Meeting of Pacific Roentgen Society.**

TUESDAY, MAY 15

9:30—Music Room, Biltmore Hotel
Joint Meeting with Section on Pediatrics

For Program, see Section on Pediatrics

WEDNESDAY, MAY 16

9:30—Conference Room 1, Biltmore Hotel

9:30—**Pancreatic Tissue in the Gastric Wall**—Lewis G. Jacobs, M.D., Oakland.

Discussion.

10:00—**Uterosalpingography with Special Reference to the Cervical Canal**—Thomas M. Fullenlove, M.D., San Francisco.

Discussion.

10:30—**Recess: Business Meeting and Election of Officers.**

10:45—**The Use of X-Ray Pelvimetry in Predicting Dystocia** — Calvin L. Stewart, M.D., San Diego.

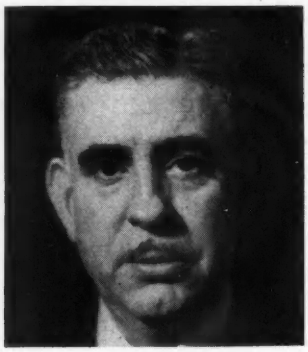
Discussion.

11:15—**Lymphosarcoma of the Stomach and Small Bowel**—Paul H. Deeb, M.D., and Walter Stilson, M.D., Los Angeles.

Discussion by Olov Bloomquist, M.D., Los Angeles.

UROLOGY

James Ownby, Jr., M.D., San Francisco, *Chairman*
Donald R. Smith, M.D., San Francisco, *Secretary*
Roger W. Barnes, M.D., Los Angeles, *Assistant Secretary*



JAMES OWNBY, JR.
Chairman

DONALD R. SMITH
Secretary

TUESDAY, MAY 15

9:30—Conference Room 9, Biltmore Hotel

Symposium

Genito-Urinary Tuberculosis

9:30—**Diagnosis of Genito-Urinary Tuberculosis**—H. H. Edelbrock, M.D., Los Angeles, by invitation.

Discussion by Lloyd R. Reynolds, M.D., San Francisco.

10:00—**Indications for Surgery in Genito-Urinary Tuberculosis**—Gilbert J. Thomas, M.D., Beverly Hills.

Discussion by J. J. Crane, M. D., Los Angeles.

10:30—**Special Techniques in Surgery of Tuberculosis of the Genito-Urinary Tract**—Thomas E. Gibson, M.D., San Francisco, and James G. Rohn, M.D., San Francisco, by invitation.

Discussion by Lyle G. Craig, M.D., Pasadena.

11:00—**Treatment of Genito-Urinary Tuberculosis with Streptomycin and Synergistic Drugs**—H. Corwin Hinshaw, M.D., San Francisco.

Discussion by Tracy O. Powell, M.D., Hollywood.

11:30—**Correlation Between Genito-Urinary and General Tuberculosis**—Carl R. Howson, M.D., and Elliot A. Rouff, M.D., Los Angeles.

Discussion by Robert J. Prentiss, M.D., San Diego.

WEDNESDAY, MAY 16

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on General Practice

For Program, see Section on General Practice

WEDNESDAY, MAY 16

2:00—Conference Room 9, Biltmore Hotel

2:00—**Chairman's Address**—James Ownby, Jr., M.D., San Francisco.

2:30—**Sexual Maladjustments**—Clyde W. Collings, M.D., Los Angeles.

Discussion by Steven F. Slepnikoff, M.D., San Francisco.

3:00—**Renal Hemangioma**—Earl F. Nation, M.D., Pasadena.

Discussion by A. A. Kutzmann, M.D., Los Angeles.

3:30—**Surgical Principles of Incising the Renal Parenchyma**—George L. Torassa, M.D., San Francisco.

Discussion by Samuel K. Bacon, M.D., Hollywood.

4:00—**Business Meeting and Election of Officers.**

Scientific Exhibits

Renaissance Room, Biltmore Hotel

Scientific Exhibit Space No. — *Exhibit*

1 **Significant Scrotal Swellings**—R. Theodore Bergman, M.D., and Roger W. Barnes, M.D., Los Angeles.

2 **The Study, Diagnosis and Surgical Treatment of Congenital Heart Disease**—Charles D. Marple, M.D., San Francisco.

3 **Save the Premature**—Robert F. Chinnock, M.D., Elizabeth Larsson, M.D., Ralph Thompson, M.D., and Milo Brooks, M.D., Los Angeles.

4 **Management of Ureteral Injury in Pelvic Surgery**—Ralph B. Mullenix, M.D., San Diego.

5 **Diseases of the Nails**—Robert H. Harris M.D., Long Beach.

6 **Child Accidents**—Esther B. Clark, M.D., Palo Alto.

7 **Tuberculosis as a Cause of Upper Lobe Bronchiectasis**—David Salkin, M.D., John S. Chase, M.D., and Edwin P. Bugbee, M.D., San Fernando.

Organizational Exhibits

Galeria, Biltmore Hotel

C.M.A. Postgraduate Activities Committee

C.M.A. Blood Bank Commission

C.M.A. Cancer Commission

Motion Picture Program

ARTHUR E. SMITH, M.D., Los Angeles, *Chairman*
Medical Motion Pictures Committee

SUNDAY, MAY 13

1:00—Biltmore Hotel, Conference Room 1

1:00—**Diagnosis of Uterine Malignancies**—American Cancer Society.

1:35—**Pathology and the Clinical Problem of Atomic Warfare**—Headquarters, Sixth Army.

2:12—**Arteriovenous Fistula With False Sac Lower Femoral Vessels**—Armed Forces Institute of Pathology, Washington, D. C.

2:28—**Genital Urinary Surgery for the General Practitioner**—Roger W. Barnes, M.D., and R. T. Bergman, M.D., Los Angeles.

2:53—**Posterior Colporrhaphy for Third Degree Laceration**—Bernard J. Hanley, M.D., Los Angeles.

3:08—**Management of Chest Injuries** — Lyman A. Brewer, M.D., and Frank S. Dolley, M.D., Los Angeles.

3:28—**Elective Supracondylar Amputation of the Thigh**—Clarence E. Rees, M.D., San Diego.

3:48—**Cooper's Ligament Herniorrhaphy** — Jack M. Farris, M.D., Los Angeles.

4:03—**Resection of a Large Thymic Tumor**—Alton Ochsner, M.D., New Orleans.

4:34—**Functions of the Nervous System**—Knowledge Builders.

4:46—**Total Abdominal Hysterectomy**—D. O. Ferris, M.D., Rochester, Minnesota.

5:06—**A Place in the Sun**—Peter Cohen, M.D., University of California, San Francisco.

5:31—**Halsted Operation for Indirect Inguinal Hernia**—Kenneth C. Sawyer, M.D., Denver.

MONDAY, MAY 14

9:00 a.m.—Sunkist Building, 707 West 5th Street (Between Grand and Flower Streets).

Auditorium, Room 200

(No Smoking)

9:00—**Congenital Atresia of the Esophagus With Tracheo-Esophageal Fistula. Surgical Repair**—Mayo Clinic, Rochester, Minnesota.

9:19—**One Stage Suprapubic Prostatectomy with Primary Wound Closure**—W. C. Eikner, M.D., Clifton Springs, New York.

9:37—**Keratoplasty**—Ramon Castroviejo, M.D., New York City.

9:49—**Surgical Treatment of Coarctation of the Aorta**—John C. Jones, M.D., Los Angeles.

10:17—**Low Cervical Cesarean Section for Twins Through the Pfannenstiel Incision Using Local Anesthesia**—T. A. Strang, M.D., Long Beach.

10:33—**Epiphrenic Esophageal Diverticulectomy** — Howard Drake, M.D., Los Angeles.

10:48—**Transthoracic Repair of Hiatus Hernia**—Edward C. Pallette, M.D., Los Angeles.

11:03—**Transverse Abdominal Incision for Cesarean Section**—D. G. Tollefson, M.D., and Keith P. Russell, M.D., Los Angeles.

11:23—**Streptomycin Drugs in Treatment of Tuberculosis**—H. Corwin Hinshaw, M.D., Stanford University, San Francisco.

11:45—**Recurrent Dislocation of the Shoulder, a Modification of the Magnuson Procedure**—William R. Molony, Jr., Los Angeles.

11:59—**A Bronchoscopic Clinic** — Paul H. Holinger, M.D., Kenneth C. Johnston, M.D., and Frank Novak, M.D., Chicago.

12:37—**Obstetric Roentgenography** — Paul C. Swenson, M.D., and Thaddeus Montgomery, M.D., Philadelphia.

12:55—**Diverticulectomy for Pulsion Diverticulum of Esophagus**—C. Douglas Sawyer, M.D., Brooklyn.

1:13—**Restoration of Lids and Brow After Massive Trauma**—Alston Callahan, M.D., University of Alabama, Birmingham.

1:33—**Cyst of Urachus**—J. Norman O'Neill, M.D., Los Angeles.

1:48—**Excision Branchial Fistula and Cyst**—Conrad J. Baumgartner, M.D., Beverly Hills.

2:08—**Cerebral Hemispherectomy: Technique**—Herbert G. Crockett, M.D., Los Angeles.

2:23—**Procidentia**—Rafe C. Chaffin, M.D., Los Angeles.

2:43—**Adenocarcinoma of Parotid Gland**—E. Eric Larson, M.D., Los Angeles.

2:58—**Technique of Thyroidectomy** — William P. Kroger, M.D., Los Angeles.

3:13—**Medical Service in Atomic Disaster** — Headquarters, Sixth Army.

3:51—**Extensive Skin Grafting in Third and Fourth Degree Burns**—Arthur E. Smith, M.D., D.D.S., Los Angeles.

4:21—**Your Ear and Noise**—Howard P. House, M.D., Los Angeles. Sub-Committee on Noise in Industry of the American Academy of Ophthalmology and Otolaryngology.

4:36—**Key Triad of the Chronic Mastoid**—Gilbert R. Owen, M.D., Los Angeles.

TUESDAY, MAY 15

9:00 a.m.—Sunkist Building, 707 West 5th Street (Between Grand and Flower Streets)

Auditorium, Room 200

(No Smoking)

9:00—**The Surgical Treatment of Hirschsprung's Disease**—Robert B. Hiatt, M.D., New York City.

9:22—**They Live Again**—American Medical Association.

9:33—**Treatment of Cleft Palate** — Lancaster Cleft Palate Clinic, Lancaster, Pennsylvania.

10:23—**Transverse Abdominal Incision for Exploration of Pheochromocytoma** — C. M. Stewart, M.D., Los Angeles.

10:38—**Polyps of the Rectum and Sigmoid** — David Miller, M.D., Los Angeles.

11:00—**The Recurrent Laryngeal Nerve in Thyroid Surgery**—Max M. Simon, Poughkeepsie.

11:18—**Hemicolectomy for Carcinoma of the Right Side of the Colon**—Philip Thorek, M.D., Chicago.

11:39—**Radical Resection of Parotid for Tumor**—Donald E. Ross, M.D., Los Angeles.

11:59—**Malignant Oral Tumors**—Armed Forces Institute of Pathology, Washington, D. C.

12:39—**Modified Guillotine Amputation Through Leg for Arteriosclerotic Gangrene With and Without Diabetes** — Beverly Chew Smith, M.D., New York City.

12:59—**Instructive Cases in Bone Surgery With Follow-up Records**—Hugh Toland Jones, M.D., Los Angeles.

1:14—**Kondoleon's Operation** — J. Norman O'Neill, M.D., Los Angeles.

1:26—**Transthoracic Resection of Carcinoma of the Gastric Cardia and Distal Esophagus**—Harold Lincoln Thompson, M.D., Los Angeles.

1:51—**Extraperitoneal Cesarean Section: A Simplified Paravesical Approach**—A. R. Abarbanel, M.D., Los Angeles.

2:06—**Anatomical Aspects of Ligamentous Injuries of the Knee**—John R. Black, M.D., Los Angeles.

2:26—**Surgical Correction of Congenital Maxillofacial Deformities**—Marsh Robinson, D.D.S., M.D., Los Angeles.

2:46—**Intravenous Anesthesia and Tracheal Intubation**—Glenn J. Potter, M.D., Los Angeles.

3:36—**Plastic Reconstruction of Mutilated Faces and Jaws Resulting From Severe Injuries**—Arthur E. Smith, M.D., D.D.S., Los Angeles.

4:11—**Highlights of Perineal Prostatectomy**—Elmer Belt, M.D., Los Angeles.

4:41—**Wounds of the Hand**—United States Navy, Washington, D. C.

TUESDAY, MAY 15

7:30 p.m.—Biltmore Hotel, Conference Room 1

7:30—**Pulsion Diverticulum of the Lower Esophagus —Transpleural One Stage Diverticulectomy**—S. W. Harrington, M.D., Rochester, Minnesota.

7:45—**Rehabilitation of a Pianist**—Henry H. Kessler, M.D., Newark.

8:00—**Intramedullary Pinning of the Femur**—Stanley S. Haft, M.D., Los Angeles.

8:12—**Abdominal Lipomatosis** — Harold I. Harris, M.D., Hollywood.

8:23—**The Treatment of Plastic Maxillary and Facial Injuries**—Henry S. Patton, M.D., Oakland. J. B. Macomber, M.D., and William McCarthy, M.D., Denver.

8:53—**Bronchiogenic Carcinoma**—Veterans Administration, Washington, D. C., American College of Surgeons.

9:13—**Carcinoma of the Gastrointestinal Tract**—American Cancer Society.

9:46—**Atomic Medical Cases, Japan, World War II** —Armed Forces Institute of Pathology, Washington, D. C.

10:23—**Wounds of the Face and Jaw**—United States Navy, Washington, D. C.

10:43—**The Repair of a Single Hare Lip by the Hagedorn-Le Mesurier Technique**—Claire L. Straith, M.D., Detroit.

10:58—**Correction of Hump Nose Using the Profilometer**—Claire L. Straith, M.D., Detroit.

WEDNESDAY, MAY 16

1:00 p.m.—Biltmore Hotel, Conference Room 1

1:00—**A Method of Cataract Extraction With the Dimitry Erisophake**—J. H. Judd, M.D., Omaha.

1:12—**Total Reconstruction of the Lower Eyelid**—Thomas D. Cronin, M.D., Houston.

1:32—**Cartilage Implant for Depressed Fracture of Orbital Margin and the Maxilla**—Wendell L. Hughes, M.D., Hempstead, New York.

1:47—**Extraperitoneal Cesarean Section—By 'Waters'**—Bernard J. Hanley, M.D., Los Angeles.

2:02—**Biesenberger Technic for Pendulous Breasts** —Harold I. Harris, M.D., Hollywood.

2:17—**Esophageal Diverticulectomy** — Conrad J. Baumgartner, M.D., Beverly Hills.

2:39—**Vaginal Hysterectomy Technic** — John C. Weed, M.D., New Orleans.

3:07—**Plastic Repair of Mandibular Prognathism**—Arthur J. Barsky, M.D., New York City.

3:22—**Reconstruction of the Hand** — William H. Frackelton, M.D., Milwaukee.

3:36—**Support of the Paralyzed Face With Fascia**—James Barrett Brown, M.D., and Frank McDowell, M.D., St. Louis.

3:55—**Open Air Therapy of Acute Extensive Burns** —T. G. Blocker, Jr., University of Texas, Galveston.

4:10—**Segmental Resection of a Portion of the Stomach and Gastroenterostomy** — Waltman Walters, M.D., Rochester, Minnesota.

4:28—**The Dermatape Method of Split Skin Grafting** —John D. Reese, M.D., Philadelphia.

4:40—**Surgical Treatment of a Congenital Heart Disease: Pulmonary Stenosis** — R. Arnold Griswold, M.D., University of Louisville, Louisville.

ANNUAL GOLF TOURNAMENT

Tuesday Afternoon, May 15

WILSHIRE COUNTRY CLUB

The Annual Golf Tournament will be held Tuesday afternoon, May 15, at the Wilshire Country Club. All members attending the meeting are welcome to play. Numerous prizes will be awarded. Make reservations with W. L. Roberts, M.D., Secretary, Southern California Medical Golf Association, 727 West Seventh Street, Los Angeles; telephone TUcker 2417.

INDEX TO SPEAKERS

Los Angeles, May 13-May 16, 1951

C. M. A. Cancer Commission Pre-Convention Conference

BILTMORE HOTEL, LOS ANGELES
SATURDAY, MAY 12

The pre-convention conferences sponsored by the Cancer Commission will be held at the Biltmore Hotel on Saturday, May 12, the day preceding the opening of the California Medical Association meeting.

PATHOLOGY

PATHOLOGY—Conference Room 1, Biltmore Hotel

The pre-convention Conference on Microscopic Tumor Pathology will be held from 9:30 a.m. to 12 noon and from 2:00 p.m. to 4:30 p.m., under the chairmanship of Dr. James E. Kahler, Los Angeles. Dr. David A. Wood, San Francisco, will be the moderator. Tumor diagnostic problems will be presented and discussed with emphasis on tumors of the intestinal tract. Members who attend this conference are requested to bring their own microscopes and to register now with Dr. E. M. Hall, Tumor Registry, Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33.

RADIOLOGY

RADIOLOGY—Conference Room 2, Biltmore Hotel

The pre-convention Conference on Radiology will be held from 9:30 a.m. to 12 noon and from 2:00 p.m. to 4:30 p.m., under the chairmanship of Dr. R. F. Niehaus, San Diego. Dr. Merrell A. Sisson of San Francisco is secretary.

SCIENTIFIC SESSIONS

	SUNDAY MAY 13		MONDAY MAY 14		TUESDAY MAY 15		WEDNESDAY MAY 16	
	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
BILTMORE THEATRE	**10:00** General Meeting		**9:00** General Medicine General Surgery	**2:00** General Meeting and Clinical-Pathological Conference				
BILTMORE HOTEL Music Room		**1:00 House of Delegates**	**9:30** General Practice		**9:30** Pediatrics Radiology	**1:00 House of Delegates**	**9:30** General Practice Urology	
Conference Room 1		**1:00 Medical Motion Pictures**			**9:30** Psychiatry and Neurology	**7:30 Medical Motion Pictures**	**9:30** Radiology	**1:00 Medical Motion Pictures**
Conference Room 2			**9:30** Radiology					
Conference Room 4							**9:30** Allergy	**2:00** Allergy
Conference Room 5			**9:30** Anesthesiology	**2:00** Anesthesiology	**9:30** Public Health		**9:30** Public Health	
Conference Room 7			**9:30** Industrial Medicine and Surgery					
Conference Room 8			**9:30** Eye, Ear, Nose and Throat	**2:00** Eye, Ear, Nose and Throat			**9:30** Pediatrics	**2:00** Pediatrics
Conference Room 9			**9:30** Psychiatry and Neurology	**2:00** Industrial Medicine and Surgery	**9:30** Urology			**2:00** Urology
BAPTIST CHURCH Burdette Hall Fifth and Olive Sts.			**9:30** Dermatology and Syphilology	**2:00** Dermatology and Syphilology	**9:30** General Medicine General Practice		**9:30** General Medicine	**2:00** General Medicine
BAPTIST CHURCH Chapel Fifth and Olive Sts.			**9:30** Pathology and Bacteriology	**2:00** Pathology and Bacteriology	**9:30** Obstetrics and Gynecology		**9:30** Obstetrics and Gynecology	
SO. CALIFORNIA EDISON BLDG. Fifth and Grand Sts.					**9:30** General Surgery		**9:30** General Surgery	
SUNKIST BUILDING Fifth and Flower Sts.			**9:00 Medical Motion Pictures**		**9:00 Medical Motion Pictures**			

COUNCIL OF THE C.M.A. MEETS DAILY AT 7:30 A.M. IN CONFERENCE ROOM 6, BILTMORE HOTEL

SCIENTIFIC EXHIBITS—RENAISSANCE ROOM, BILTMORE HOTEL

HOUSE OF DELEGATES MEETS SUNDAY AND TUESDAY, 1:00 P.M.

WOMAN'S AUXILIARY

to the

CALIFORNIA MEDICAL ASSOCIATION

Twenty-First Annual Convention, May 13-15, 1951

Headquarters: Biltmore Hotel, Los Angeles, California

MRS. WILLIAM R. MOLONY, JR.
President

MRS. STANLEY R. TRUMAN
President-Elect

Convention Chairman: MRS. ARTHUR HURD

REGISTRATION

Sunday, May 13—9:00 a.m. - 12 noon
Monday, May 14—9:00 a.m. - 5:00 p.m.
Tuesday, May 15—9:00 a.m. - 12 noon
Main Galeria, Biltmore Hotel

SUNDAY, MAY 13

8:00 a.m.—Executive Committee Meeting, President's Suite, Biltmore Hotel.

10 a.m.—Opening Session of the California Medical Association. Report of the year's work of the Woman's Auxiliary by the President, Mrs. William R. Molony, Jr. All Auxiliary members and doctors' wives are invited to attend. Biltmore Theatre.

10:30 a.m. — Pre - Convention Board Meeting, Conference Room 9, Biltmore Hotel.

MONDAY, MAY 14

9:30 a.m.—First General Session of the 21st Annual Meeting, Ballroom, Alexandria Hotel, 210 West Fifth Street. Mrs. William R. Molony, Jr., President, presiding.

4:00 - 6:00 p.m.—Reception, honoring Mrs. Donald Cass, wife of the President of the California Medical Association. All doctors' wives and their husbands are invited. Music Room, Biltmore Hotel.

7:30 p.m.—California Medical Association Dinner and Dance, honoring the President, Dr. Donald Cass. Biltmore Bowl, Biltmore Hotel.

TUESDAY, MAY 15

9:00 a.m.—Second General Session of the 21st Annual Meeting. Ballroom, Alexandria Hotel, 210 West Fifth Street.

12:00 to 12:30 p.m.—School of Instruction for County Presidents, Officers, and Committee Chairmen. Ballroom, Alexandria Hotel.

1:00 p.m.—Luncheon honoring Mrs. William R. Molony, Jr., Mrs. Stanley R. Truman, the State Advisory Board, and Past State Presidents. Biltmore Bowl, Biltmore Hotel.

3:00 p.m. — Post-Convention Board Meeting. Conference Room 7, Biltmore Hotel. Mrs. Stanley R. Truman, presiding.

Technical Exhibits

This year the Association welcomes the largest technical exhibit in its history. The Ball Room, Ball Room Foyer and the Renaissance Room will be given over to this exhibit, and in these quarters will be found the latest developments in apparatus, pharmaceuticals, biologics and services. Your attendance at the exhibits is earnestly urged.

Exhibitors at C.M.A. meetings are carefully screened as to the quality and efficacy of their products or services. Physicians may be assured that the items on display are accurate and representative of the finest in their respective fields. A veritable postgraduate course is available in a thorough visit among the exhibits.

The schedule of meetings has been arranged to permit two free afternoons. We suggest that this time may be profitably used by touring the exhibit areas and catching up on the newest and best in the products displayed. Competent, courteous representatives are at your service, ready and anxious to answer your questions and bring you the latest information on their products and services.

The exhibitors pay for the privilege of displaying their commodities to you; in fact, their financial contribution makes possible the scheduling of the entire meeting. For this, if not for yourself, a visit to the exhibits is indeed indicated.

ABBOTT LABORATORIES
Booth No. 16 ..... Ballroom

A. S. ALOE COMPANY
Booth No. 64 ..... Renaissance Room

AMES COMPANY, INC.
Booth No. 24 ..... Ballroom

AYERST, McKENNA & HARRISON LIMITED
Booth No. 27 ..... Ballroom

BABY DEVELOPMENT CLINIC
Booth No. 89 ..... Renaissance Room

BAKER LABORATORIES, INC., THE
Booth No. 31 ..... Ballroom

BARNES-HIND LABORATORIES, INC.
Booth No. 78 ..... Renaissance Room

DON BAXTER, INC.
Booth No. 41 ..... Ballroom Foyer

BILHUBER-KNOLL CORP.
Booth No. 14 ..... Ballroom

BORDEN COMPANY, THE
Booth No. 60 ..... Renaissance Room

BORDEN COMPANY, THE, EVAPORATED MILK DIVISION
Booth No. 59 ..... Renaissance Room

A. M. BROOKS COMPANY
Booth No. 81 ..... Renaissance Room

BURROUGHS WELLCOME & COMPANY
Booth No. 17 ..... Ballroom

CAMEL CIGARETTES
Booths Nos. 2 and 3 ..... Ballroom

CAMERON SURGICAL SPECIALTY COMPANY
Booth No. 42 ..... Ballroom Foyer

ELDON H. CANRIGHT COMPANY, INC.
Booth No. 93 ..... Renaissance Room

CARNATION COMPANY
Booth No. 35 ..... Ballroom Foyer

CIBA PHARMACEUTICAL PRODUCTS, INC.
Booth No. 13 ..... Ballroom

COCA-COLA COMPANY, THE
Booth No. 56 ..... Renaissance Room

COMMERCIAL SOLVENTS CORPORATION
Booth No. 49 ..... Ballroom Foyer

CONTINENTAL MEDICAL BUREAU, Agency
Booth No. 77 ..... Renaissance Room

CUTTER LABORATORIES
Booth No. 45 ..... Ballroom Foyer

G. DANZ & SONS
Booth No. 67 ..... Renaissance Room

DESITIN CHEMICAL COMPANY
Booth No. 88 ..... Ballroom Foyer

DEVEREUX FOUNDATION, THE
Booth No. 48 ..... Ballroom Foyer

DIETENE COMPANY, THE
Booth No. 12 ..... Ballroom

DOHO CHEMICAL CORPORATION
Booth No. 80 ..... Renaissance Room

EATON LABORATORIES, INC.
Booth No. 11 ..... Ballroom

ENDO PRODUCTS, INC.
Booth No. 54 ..... Ballroom Foyer

C. B. FLEET CO., INC.
Booth No. 26 ..... Ballroom

ROLAND J. GAUPEL COMPANY
Booth No. 75 ..... Renaissance Room

GENERAL ELECTRIC X-RAY CORPORATION
Booth No. 91 ..... Renaissance Room

GERBER PRODUCTS COMPANY
Booth No. 21 ..... Ballroom

OTIS E. GLIDDEN & CO., INC.
Booth No. 76 ..... Renaissance Room

JOHN F. GREER COMPANY
Booth No. 20 ..... Ballroom

HAMILTON-DAUGHERTY, INC.
Booth No. 37 ..... Ballroom Foyer

HARROWER LABORATORY, INC., THE
Booth No. 69 ..... Renaissance Room

H. J. HEINZ COMPANY
Booth No. 73 ..... Renaissance Room

HOFFMANN-LA ROCHE, INC.
Booth No. 5 ..... Ballroom

HOLLAND-RANTOS COMPANY, INC.
Booth No. 66 ..... Renaissance Room

LANTEEN MEDICAL LABORATORIES, INC.
Booth No. 68 ..... Renaissance Room

LEDERLE LABORATORIES
Booth No. 18 ..... Ballroom

LIBBY, McNEILL & LIBBY
Booth No. 79 ..... Renaissance Room

LIEBEL-FLARSHEIM COMPANY, THE
Booth No. 46 ..... Ballroom Foyer

ELI LILLY AND COMPANY
Booth No. 40 ..... Ballroom Foyer

J. B. LIPPINCOTT COMPANY
Booth No. 51 ..... Ballroom Foyer

LOV-É BRASSIERE COMPANY
Booth No. 7 ..... Ballroom

M & R DIETETIC LABORATORIES
Booth No. 30 ..... Ballroom

MARLYN CO., INC.
Booth No. 52 ..... Ballroom Foyer

S. E. MASSENGILL COMPANY, THE
Booth No. 28 ..... Ballroom

McNEIL LABORATORIES, INC.
Booth No. 47 ..... Ballroom Foyer

MEAD JOHNSON & COMPANY
Booth No. 34 ..... Ballroom Foyer

MEDCO PRODUCTS CO.
Booth No. 85 ..... Renaissance Room

MEDICAL PROTECTIVE COMPANY, THE
Booth No. 55 ..... Ballroom Foyer

MERCK & CO., INC.
Booth No. 29 ..... Ballroom

WILLIAM S. MERRELL COMPANY, THE
Booth No. 4 ..... Ballroom

C. V. MOSBY COMPANY, THE
Booth No. 22 ..... Ballroom

NATIONAL DRUG COMPANY
Booth No. 65 ..... Renaissance Room

NESTLE COMPANY, INC., THE
Booth No. 10.....Ballroom

NETTLESHIP COMPANY, THE
Booth No. 94.....Renaissance Room

ORTHO PHARMACEUTICAL CORPORATION
Booth No. 9.....Ballroom

PACIFIC COAST MEDICAL BUREAU
Booth No. 77.....Renaissance Room

PARKE, DAVIS & CO.
Booth No. 50.....Ballroom Foyer

PELTON & CRANE CO.
Booth No. 43.....Ballroom Foyer

PET MILK COMPANY
Booths Nos. 38 and 39.....Ballroom Foyer

PHILIP MORRIS & CO., LTD., INC.
Booth No. 63.....Renaissance Room

PICKER X-RAY
Booth No. 8.....Ballroom

RICHARDS MANUFACTURING COMPANY
Booth No. 71.....Renaissance Room

RIKER LABORATORIES, INC.
Booth No. 83.....Renaissance Room

A. H. ROBINS COMPANY, INC.
Booth No. 57.....Renaissance Room

J. B. ROERIG & COMPANY
Booth No. 74.....Renaissance Room

SANBORN COMPANY
Booth No. 61.....Renaissance Room

SANDOZ PHARMACEUTICALS
Booth No. 87.....Renaissance Room

W. B. SAUNDERS COMPANY
Booth No. 1.....Ballroom

R. L. SCHERER COMPANY
Booth No. 44.....Ballroom Foyer

SCHERING CORPORATION
Booth No. 15.....Ballroom

JULIUS SCHMID, INC.
Booth No. 95.....Renaissance Room

G. D. SEARLE & CO.
Booth No. 36.....Ballroom Foyer

SHARP & DOHME, INC.
Booth No. 33.....Ballroom Foyer

SMITH-DORSEY COMPANY, THE
Booth No. 62.....Renaissance Room

SMITH, KLINE & FRENCH LABORATORIES
Booth No. 19.....Ballroom

E. R. SQUIBB & SONS
Booth No. 53.....Ballroom Foyer

J. W. STACEY, INC.
Booth No. 90.....Renaissance Room

STAYNER CORPORATION
Booth No. 84.....Renaissance Room

STUART COMPANY, THE
Booth No. 92.....Renaissance Room

UNITED LABORATORIES, LTD.
Booth No. 72.....Renaissance Room

U. S. VITAMIN CORPORATION
Booth No. 23.....Ballroom

VAISEY-BRISTOL SHOE CO., INC.
Booth No. 70.....Renaissance Room

VARICK PHARMACAL CO., INC.
Booth No. 6.....Ballroom

WALKER VITAMIN PRODUCTS, INC.
Booth No. 58.....Renaissance Room

WALTERS SURGICAL COMPANY
Booth No. 43.....Ballroom Foyer

WESTWOOD PHARMACAL CORPORATION
Booth No. 25.....Ballroom

WHITE LABORATORIES, INC.
Booth No. 32.....Ballroom

WINTHROP-STEARNS, INC.
Booth No. 86.....Renaissance Room

WYETH, INCORPORATED
Booth No. 82.....Renaissance Room

About the Exhibitors

ABBOTT LABORATORIES — Booth No. 16
North Chicago, Illinois

Abbott will exhibit a number of its leading products, such as ABBOCILLIN-DC, 600,000 units of penicillin in a 1-cc. cartridge; IBEROL, a vitamin B complex and liver concentrate tablet; DUOZINE DULCETS, a combination of sulfadiazine and sulfamerazine in candy form; DAYAMIN, a pleasantly flavored multiple vitamin capsule, and OPTILETS, a therapeutic formula tablet containing six synthetic vitamins, plus vitamin B_{12}.

A. S. ALOE COMPANY — Booth No. 64
Los Angeles

We plan to display the latest and most modern in office furniture including our new and exclusive contour Steeline examining and treatment room furniture.

We also will show a complete line of Physio Therapy equipment, X-ray, Beck Lee Cardiall, Aloetherm, Aloetron, etc.

A representative line of general and specialized instruments will be shown for your inspection.

AMES COMPANY, Inc. — Booth No. 24
Elkhart, Indiana

Ames Company representatives will be glad to discuss DECHOLIN and DECHOLIN SODIUM, the standard hydrocholeretic agents for the treatment of biliary tract diseases.

They will be demonstrating CLINITEST, ACETEST, BUMINTEST, and HEMATEST, simplified tests for the detection of urine-sugar, acetone bodies, albumin, and occult blood.

AYERST, McKENNA & HARRISON, Ltd.
New York, New York — Booth No. 27

Physicians attending the California Medical Association meeting are cordially invited to visit the Ayerst booth. Our representatives will be happy to answer your inquiries relative to "Premarin," "Premarin" with Methyltestosterone, and all other Ayerst specialties.

BABY DEVELOPMENT CLINIC — Booth No. 89
Chicago, Illinois

The Baby Development Clinic will feature the psychological aspects of feeding, as well as several products suited to infant and child feeding and care. The manufacturers of these products support the educational work of this organization.

The Baby Development Clinic will announce a new service to be known as the Maternity Counselling Service which will be of interest to doctors for their maternity patients.

THE BAKER LABORATORIES — Booth No. 31
Cleveland, Ohio

"Baker's" Modified Milk (powder and liquid) and Varamel (liquid) are especially made, from Grade A milk, for the bottle-fed baby. Baker's is completely prepared and only water needs to be added. Varamel is the new formula base to which carbohydrate and water are added in accordance with the needs of the infant. Our representatives will be glad to tell you more about these products.

BARNES-HIND LABORATORIES, Inc.
San Francisco **Booth No. 78**

Barnes-Hind Laboratories, Inc. takes great pleasure in bringing to the medical profession several of our newest products, namely: Pasna Granules, Pasna Lyophilized, Water Dispersible Vitamin A, and the new lipotropic agents, MIC Liquid and MIC tablets.

DON BAXTER, Inc. **Booth No. 41**
Glendale

The Baxter exhibit will feature new solutions including Kaladex, Baxter's Potassium solution, Ammonium Chloride, Hyprotigen with Alcohol, and dilute Procaine solutions. New, improved blood collection bottles and equipment will also be shown. One of the features of the exhibit will be the new and interesting line of Baxter Expendable Plastic Tubes and Catheters.

BILHUBER-KNOLL CORP. **Booth No. 14**
Orange, New Jersey

Visit the Bilhuber-Knoll Booth No. 14 for the latest information on Valoctin, the new sedo-spasmolytic. Your discussions of this and their original medicinal chemicals, such as Bromural, Dilaudid, Theocalcin, Metrazol, etc., will be cordially welcomed.

THE BORDEN COMPANY **Booth No. 60**
New York, New York

Borden representatives will be more than pleased to discuss a new powdered infant food with you. Bremil is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted in order to supply the nutritional requirements of infants deprived of human milk. Clinical, x-ray and laboratory evidence with a large group of infants fed exclusively on Bremil proved conclusively its efficacy as an infant food. Bremil is a new phase in infant feeding.

THE BORDEN COMPANY—Evaporated Milk Div.
San Francisco **Booth No. 59**

Our special representatives will be in the booth to answer questions and distribute special approved literature. The animated baby will be there to encourage your smiles. Borden's 100 per cent Instant Coffee will be served.

A. M. BROOKS COMPANY **Booth No. 81**
Los Angeles

We shall be happy to meet our many friends in Booth No. 81, where we shall again feature the outstanding diathermy of the year, the Raytheon (radar) Microtherm. Also, Edin cardiograph, ADC Audiometers, AMBCO Hearing Amplifiers, and many other physical therapy items, such as Sinewaves, Vasculator, Whirlpool bath, Quartz and Infra-red lamps, etc. Competent salesmen on hand to demonstrate all equipment.

BURROUGHS WELLCOME & COMPANY
New York, New York **Booth No. 17**

Intermediate-acting GLOBIN INSULIN 'B.W.&Co.' will be a feature product. GLOBIN INSULIN, a clear solution which requires no preliminary shaking, is now official in the U.S.P.—the only intermediate-acting insulin to receive this recognition. We will also feature 'PERAZIL' brand Chlorcyclizine Hydrochloride, the chemically different antihistaminic with longer action and fewer side-effects; and 'EMPIRAL,' which combines the well-known analgesic action of 'Tabloid' 'Empirin' compound with the sedative action of phenobarbital.

CAMEL CIGARETTES **Booths Nos. 2 and 3**
New York, New York

Camel cigarettes will exhibit a large detailed photograph showing the calculated absorption of nicotine from cigarette smoke in the human respiratory tract. Representatives will be on hand to discuss any phase of the physiological effects of smoking.

CAMERON SURGICAL SPECIALTY COMPANY
Chicago, Illinois **Booth No. 42**

See the new Cameron Surgical Diathermy Units and accessories for all phases of Electro-Surgery, Electro-Cauterization, Electro-Coagulation, Desiccation, Fulguration and orificial Ultra-Violet treatment; Electro-Diagnostic Lamp and Instrument Outfits; the Boros Flexible Esophagoscope and other Peroral Endoscopic Equipment; Coagulair and Dualite Sigmoidoscopes; Tele-Vaginalite and Radiolucent Uterine Cannula; Mirrolite and other Headlights; Binocular Loupes; Illuminated Specula, Endoscopes and Retractors, and other instruments for general and special Diagnosis, Treatment and Surgery.

ELDON H. CANRIGHT COMPANY, Inc.
Glendale **Booth No. 93**

You are invited to visit the Eldon H. Canright Company booth where our specialty prescription formulas will be on exhibit. Descriptive literature will be available, and courteous personnel will be in attendance.

CARNATION COMPANY **Booth No. 35**
Los Angeles

You are invited to visit the Carnation Company booth, No. 35, where you will see an attractive display presenting some interesting information on the various uses of Carnation Vitamin D Evaporated Milk for infant feeding, child feeding, and general diet purposes. The method by which Carnation Milk is generously fortified with Vitamin D—400 U.S.P. units per reconstituted quart—will be explained. Valuable literature will also be available for distribution.

CIBA PHARMACEUTICAL PRODUCTS, Inc.
Summit, New Jersey **Booth No. 13**

Ciba Pharmaceutical Products, Inc., Booth No. 13, invites you to visit its exhibit which will feature Pyribenzamine in the treatment of drug dermatoses, showing the action of this effective antihistaminic when absorbed through damaged skin and by oral administration.

Representatives in attendance will be glad to answer questions about Pyribenzamine and other Ciba products used in dermatology.

THE COCA-COLA COMPANY **Booth No. 56**
Los Angeles

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Los Angeles and the Coca-Cola Company.

COMMERCIAL SOLVENTS CORPORATION
New York, New York **Booth No. 49**

C.S.C. Pharmaceuticals will feature a number of new items in addition to its line of bacitracin and penicillin preparations. Included will be an improved lipotropic agent combining choline and inositol, a new hypertensive agent, and a diagnostic aid for determining the antibiotic of choice in the treatment of specific cases. Also on display will be new products which contain antibiotics in combination. Through synergism, a combination of antibiotics may be more effective than each antibiotic alone.

CONTINENTAL MEDICAL BUREAU, Agency
San Francisco and Los Angeles **Booth No. 77**

CONTINENTAL MEDICAL BUREAU, Agency, Los Angeles, now incorporated with PACIFIC COAST MEDICAL BUREAU, Agency, San Francisco, will be represented in Booth 77. This bureau is California's oldest and best known medical placement agency and handles medical personnel exclusively. If you wish an associate in your practice stop by and review files on men who are available; if you wish to relocate or dispose of equipment or practice they offer prompt and confidential services. Nurses, technicians and medical secretaries available for placement. Two offices to serve you. 1406-1412 Central Tower, San Francisco 3, or 510 West Sixth Street, Los Angeles 14 (Helen Buchan, Director).

CUTTER LABORATORIES **Booth No. 45**
Berkeley

Cutter Laboratories, Berkeley, invite your comments on our complete line of pediatric immunizing agents. These pediatric products are purified in our own blood fractions laboratories. The purification method gives less reaction with higher immunity with only a 0.5-cc. dosage.

The exclusive line of Cutter human blood fractions includes Albumin, Immune Serum Globulin, Hypertussis and Plasma, all of which will be shown.

We invite your comments on the new all-plastic expendable blood administration sets which were designed for positive pressure.

G. DANZ & SONS **Booth No. 67**
San Francisco

You are cordially invited to visit our booth and see our display of ophthalmic prosthetics, ophthalmic implants and corneal contact lenses.

DESITIN CHEMICAL CO. **Booth No. 88**
Providence, Rhode Island

Desitin Ointment, the pioneer in external cod liver oil therapy, combines crude high potency Norwegian cod liver oil, zinc oxide, and talcum in a modified lanolin petrolatum base. Owing to its content of high natural vitamin A and D concentration and unsaturated fatty acids, Desitin Ointment alleviates pain and relieves itching promptly. It promotes granulation and epithelization. Desitin Ointment is not liquefied at body temperature nor decomposed by secretions. Desitin Ointment forms a perfect protection for the skin. Indications: Postoperative dressings, slow-healing wounds, indolent chronic varicose ulcers, burns of all degrees, lacerations, bed sores, hemorrhoids and fissures.

Desitin Powder, a unique, dainty medicinal toilet powder, contains crude cod liver oil, zinc oxide, magnesium oxide and talcum. Uses: As of Desitin Ointment.

DEVEREUX RANCH SCHOOL **Booth No. 48**
Santa Barbara

Devereux Schools provide the physician with facilities for the education and treatment of children having academic or emotional difficulties. Twelve Devereux Schools in Pennsylvania, as well as the Devereux Ranch School in California, offer a controlled environment and modern training shaped to the needs of each child. At Santa Barbara, the 350-acre ranch school bordering on the Pacific Ocean has an enrollment of 70 children. In Pennsylvania, there are facilities for over 400 students. Representatives at the booth will gladly answer questions or discuss how Devereux may serve you and your patients.

THE DIETENE COMPANY **Booth No. 12**
Minneapolis, Minnesota

Visit our exhibit and examine the Free Diet Service for physicians. The diets are nutritionally well-balanced, easy to follow and made to appear as if they were typed in your office.

MERITENE, the economical and palatable whole protein supplement, and DIETENE, the "Council-Accepted" reducing supplement, will be on display.

DOHO CHEMICAL CORPORATION
New York, New York **Booth No. 80**

The Doho Chemical Corporation and its subsidiary, Mallon Chemical Corporation, makers of AURALGAN, RECTALGAN and O-TOS-MO-SAN, are proud to announce their new nasal decongestant, RHINALGAN—a balanced formulation of two active chemical compounds that gives prolonged vasoconstriction—used as a spray, in our patented Dohony Spray-O-Mizer (combination dropper and spray), pleasant tasting, with no systemic effect (pressor or respiratory) and can be safely used for infants and children.

Our representatives will be happy to explain the merits of RHINALGAN and distribute samples of this innovation.

EATON LABORATORIES, Inc. **Booth No. 11**
Norwich, New York

For rapid control of tinea capitis and other dermatomycoses: the new Furaspor Cream: fungicidal-sporicidal-bactericidal.

For more efficient control of bacterial surface infections, Furacin is now available as Furacin Soluble Dressing, Furacin Solution, Furacin Anhydrous Ear Solution, Furacin Vaginal Suppositories and Furacin Ophthalmic Liquid and Ointment.

For efficient control of gastric acidity: Aspogen, the basic aluminum salt of an amino acid.

For efficient control of conception when pregnancy is contraindicated: Lorophyn suppositories and jelly.

For systemic sulfonamide therapy: Tripazine, a triple sulpha' tablet sine sulfathiazole.

For control of scabies and pediculosis with one application: Paracin Liquid and Ointment.

ENDO PRODUCTS, Inc. **Booth No. 54**
Richmond Hill, New York

Our representatives will be happy to discuss with you, HYCODAN, the preferred anti-tussive, Norodin, Mesopin and other Council-Accepted products. We will also have available, information on Nucodan and Percodan, the new analgesic drugs developed by Endo Research Laboratories.

C. B. FLEET COMPANY, Inc. **Booth No. 26**
Lynchburg, Virginia

C. B. Fleet Company, Inc., cordially invites you to stop at Booth 26 to see the exhibit of Phospho-Soda (Fleet). Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 gm. and sodium phosphate 18 gm.

Phospho-Soda (Fleet) over the years has won discriminating preference by thousands of physicians—because of its controlled action—its freedom from undesirable side-effect, and its ease of administration.

There is only One Phospho-Soda (Fleet).

ROLAND J. GAUPEL COMPANY
Los Angeles **Booth No. 75**

The Roland J. Gaupel Company will have on display some of its newest products made in California. Among items exhibited will be x-ray accessories, featuring view boxes, cassette holders, calipers, hanger racks, film markers, etc. We will also have treatment tables and Profex X-ray equipment, featuring the new 100-100 machine.

GENERAL ELECTRIC X-RAY CORPORATION
Milwaukee, Wisconsin **Booth No. 91**

Latest type of shockproof x-ray equipment will be shown. General Electric also distributes Electric Cardioscribes, Short-Wave Diathermy; Ultra-Violet and Infra Red lamps.

GERBER PRODUCTS COMPANY
Oakland **Booth No. 21**

Announcing—Gerber's Rice Cereal. This one-grain infant cereal is particularly hypoallergenic and distinctively acceptable to young infants. It is the ideal "starting" cereal. Ask the Gerber representative for literature and samples.

OTIS E. GLIDDEN & CO., Inc. Booth No. 76
Evanston, Illinois

Presenting Zymelose Tablets—a fine new product by the makers of Zymenol. Zymelose is a special high-viscosity hydrophilic cellulose derivative with Brewers Yeast which produces bulk where bulk is needed—in the intestines only. The physician is offered his choice of effective bowel management with Zymelose (tablets) or Zymenol (emulsion). Both with Brewers Yeast—both non-habit forming.

JOHN F. GREER COMPANY Booth No. 20
Oakland

The John F. Greer Company will show the improved Greer Colostomy Compact (irrigator and pouch), as well as a new Ileostomy outfit. These appliances are the result of more than twenty years' experience in the manufacture of postoperative appliances.

HAMILTON-DAUGHERTY, Inc. Booth No. 37
Beverly Hills

Hamilton-Daugherty, Inc., devote their efforts exclusively to the design of Medical buildings. They have on display in Booth 37 innumerable photographs in color and continuous projection of color slides of exteriors and interiors of Medical buildings designed by them.

They are an authority on this subject and have an unlimited source of information for those interested. Their knowledge of the Doctor's requirements, and experience in this field can be of unprecedented value to you when you contemplate a new office or building. Your office is your daytime home. It should reflect your personality—be cheerful, restful, and efficient.

THE HARROWER LABORATORY, Inc.
Glendale **Booth No. 69**

The Harrower Laboratory, Inc., technical exhibit will introduce two new pharmaceutical products. Samples and literature on these products will be available.

H. J. HEINZ COMPANY Booth No. 73
Pittsburgh, Pennsylvania

Stop at the Heinz exhibit for these: Nutritional Data, Nutritional Observatory. Do you need Baby Gift Folders for distribution among your patients? Have you seen the additions to Heinz Baby Food line—Strained Pears and Strained Sweet Potatoes? New Junior Foods are Pears, Pears and Pineapple, Custard Pudding, Chicken Soup, Vegetable Soup, Green Beans, and Carrots.

HOFFMANN-LA ROCHE, Inc. Booth No. 5
Nutley, New Jersey

Roche will feature GANTRISIN, the new sulfonamide which has outstanding therapeutic advantages. GANTRISIN is distinguished by comparatively high solubility even in neutral and slightly acid solutions. It is not likely to cause crystalluria and it does not require concomitant alkali therapy. GANTRISIN is highly effective in the treatment of systemic and urinary tract infections.

Why not stop at the Roche booth where members of the field staff will be in attendance to tell you more about GANTRISIN, the radically different sulfonamide.

HOLLAND-RANTOS COMPANY, Inc.
New York, New York **Booth No. 66**

Ask H-R representative (1) why it is to your advantage and that of patients to specify KOROMEX Diaphragms, Jelly and Cream for *dependable* conception control; (2) why NYLMERATE JELLY is so effective in treatment of vaginal trichomoniasis and moniliasis; (3) what other H-R products would be useful in your practice.

LANTEEN MEDICAL LABORATORIES, Inc.
Evanston, Illinois **Booth No. 68**

Lanteen Medical Laboratories, Inc., cordially invite you to visit their booth. Our representatives will be happy to discuss the latest developments in diaphragm fitting technique embodying the Lanteen Flat Spring Diaphragm. Also on display for discussion will be ALKAGEL and PROCARMIN, as well as other well-known Lanteen products.

LEDERLE LABORATORIES Booth No. 18
New York, New York

You are cordially invited to visit our exhibit in Booth 18, where you will find representatives who are prepared to give you the latest information on Lederle products.

LIBBY, McNEILL & LIBBY Booth No. 79
Chicago, Illinois

Libby, McNeill & Libby welcomes the opportunity to participate in the 1951 California Medical Association convention. Trained representatives will be available to discuss the merits of Libby's Homogenized Baby Foods which are so ideal for baby's first solid foods.

THE LIEBEL-FLARSHEIM COMPANY
Cincinnati, Ohio **Booth No. 46**

Visit Booth 46: There you will see the Famous Liebel-Flarsheim FCC-Approved Short Wave Diathermy and the new Improved Electrosurgical Units. Trained representatives to serve you and explain the many advantages of Liebel-Flarsheim equipment; a leader in its field for many years. We look forward to your visiting our booth.

ELI LILLY AND COMPANY Booth No. 40
Indianapolis, Indiana

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Booth 40. Many new therapeutic developments will be featured and literature on these products will be available. Visiting physicians will be aided in every way possible.

J. B. LIPPINCOTT COMPANY Booth No. 51
Philadelphia, Pennsylvania

J. B. Lippincott Company presents an interesting and active exhibit of professional publishing. With the "pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine and surgery are known continually. On the studied recommendations of these medical leaders, Lippincott Selected Professional Books are undertaken.

LOV-É BRASSIERE COMPANY Booth No. 7
Hollywood

We invite you to inspect our highly specialized line of therapeutic breast supports which enable the physician to prescribe remedial support for specific breast conditions. Each LOV-E brassiere is custom-fitted inch-by-inch to your patient's personal measurements—and in exact accordance with your instructions. Special brassieres for prenatal, postpartum, atrophic, hypertrophic and mastectomy. LOV-E Corrective Brassieres are available in leading department stores and corset shops throughout the West. Our representative will be very happy to answer any questions.

M & R DIETETIC LABORATORIES, Inc.
Columbus, Ohio **Booth No. 32**

Our representatives for Similac and Cerevim will appreciate the opportunity to discuss with you the merits and use of our products in the field of infant and child nutrition.

MARLYN COMPANY, Inc. **Booth No. 52**
Los Angeles

Marlyn Company, Inc. will feature Test-Estrin, a combination of male and female hormones in physiologic ratio. A staff of representatives will be on hand at all times, and we cordially invite you to visit our booth.

THE S. E. MASSENGILL COMPANY
Bristol, Tennessee **Booth No. 28**

Featuring A.M.A. Council-accepted products. Our exhibit will emphasize multiple sulfonamide therapy in combination with penicillin.

McNEIL LABORATORIES, Inc. **Booth No. 47**
Philadelphia, Pennsylvania

McNeil Laboratories, Inc. will exhibit in Booth 47 pharmaceutical specialties of interest to the physician. Mr. David H. Heaton will be in charge. Please stop by and meet our representatives.

MEAD JOHNSON & COMPANY **Booth No. 34**
Evansville, Indiana

Dextri-Maltose, Oleum Percomorphum, Pablum, Pabena, Olac and other Mead Products used in Infant Nutrition will be on display at the Mead Johnson Exhibit at your California Medical Association meeting. Protenum, a new high protein product, will be displayed. Also, Lonalac, for low sodium diets. Our representatives at the exhibit will be glad to discuss with you the new improvements of Amigen and Amisets.

MEDCO PRODUCTS CO. **Booth No. 85**
Tulsa, Oklahoma

Medcotronic Stimulator, low-volt generator, will be on display. Indicated for Supplemental Rehabilitation of chronic and acute cases of myositis, neuritis, fibrositis, low back pains, bursitis, muscular dystrophies, peripheral vascular disorders, paralysis, rheumatism and arthritis.

THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana **Booth No. 55**

The Medical Protective Company's representative, trained in Professional Liability Underwriting, invites you to visit our Booth 55. He is entirely familiar with the principles of the reciprocal rights and duties of a doctor and patient and with the circumstances peculiar to that relationship. He will be glad to explain how his Company meets the exacting requirements of adequate liability protection which are peculiar to the Professional Liability Field.

MERCK & CO., Inc. **Booth No. 29**
Rahway, New Jersey

Merck & Co., Inc. features CORTONE-Acetate (Cortisone Acetate MERCK). Among the conditions in which CORTONE has produced striking clinical improvement are: Rheumatoid Arthritis and related rheumatic diseases; acute rheumatic fever; bronchial asthma; eye diseases including nonspecific iritis, iridocyclitis, uveitis, and sympathetic ophthalmia; skin diseases, notably pemphigus, angioneurotic edema, atropic dermatitis, and exfoliative dermatitis, including cases secondary to drug reactions.

THE WM. S. MERRELL CO. **Booth No. 4**
Cincinnati, Ohio

Bentyl hydrochloride, a high-milligram-potency non-narcotic antispasmodic with twofold musculotropic and neurotropic action, will be featured at our booth. Bentyl is effective therapeutically without central nervous stimulation or atropine-like side effects.

THE C. V. MOSBY COMPANY **Booth No. 22**
San Francisco

Many new books and new editions will be at the Mosby Company booth for you to look over at your leisure.

NATIONAL DRUG COMPANY **Booth No. 65**
New York, New York

THE NESTLE COMPANY, Inc. **Booth No. 10**
Colorado Springs, Colorado

For your relaxation, the Nestle Company cordially invites you to enjoy a delicious, hot cup of Nescafe. And, for your information, specially qualified representatives will be on hand to answer your questions on any of Nestle's milk products—already best known and most used for babies 'round the world.

THE NETTLESHIP COMPANY **Booth No. 94**
Los Angeles

Information on insurance problems of the doctor will be available to attending physicians. The Nettleship Company has specialized in the field of the professional man for 25 years, presently administering the official malpractice insurance programs of six county medical associations. It likewise serves nine professional organizations as administrators of their Group Accident and Sickness insurance programs. Many members of the profession have found it desirable to avail themselves of the services of the general insurance and life insurance departments of The Nettleship Company, due to the specialized attention given to the doctor's insurance needs.

ORTHO PHARMACEUTICAL CORPORATION
Raritan, New Jersey **Booth No. 9**

Ortho cordially invites you to visit Booth 9. Featured will be the ORTHO KIT, a new, convenient, and complete kit containing the requisites for conception control in a beautiful woven plastic zippered purse. New products displayed will include DIFFUSIN (hyaluronidase), MASSE Nipple Cream, and other new gynecic pharmaceuticals.

PACIFIC COAST MEDICAL BUREAU, Agency
San Francisco and Los Angeles **Booth No. 77**

PACIFIC COAST MEDICAL BUREAU, Agency, San Francisco, now incorporated with CONTINENTAL MEDICAL BUREAU Agency, Los Angeles, will be represented in Booth 77. This bureau is California's oldest and best known medical placement agency and handles medical personnel exclusively. If you wish an associate in your practice stop by and review files on men who are available; if you wish to relocate or dispose of equipment or practice they offer prompt and confidential services. Nurses, technicians and medical secretaries available for placement. Two offices to serve you. 1406-1412 Central Tower, San Francisco 3, or 510 West Sixth Street, Los Angeles 14 (Helen Buchan, Director).

PARKE, DAVIS & COMPANY **Booth No. 50**
Detroit, Michigan

Medical Service Members of the PARKE, DAVIS & COMPANY Staff will be in daily attendance at our commercial exhibit for consultation and discussion of the various products listed in our Pharmaceutic, Antibiotic, and Biologic Catalog. Important Specialties, such as Chloromycetin, Peni-

cillin S-R, Benadryl, Vitamins, Oxycel, Thrombin Topical, Influenza Virus Vaccine, and others will be featured. You are most cordially invited to visit our exhibit with the assurance that your personal interest will indeed be very much appreciated.

PELTON & CRANE COMPANY **Booth No. 43**
Detroit, Michigan

Pelton and Crane will exhibit in Booth 43 their latest sterilizers. They will have on display their large autoclaves and cabinet sterilizers. Competent representatives will gladly assist you in selecting the proper equipment for your office or hospital.

PET MILK COMPANY **Booths Nos. 38 and 39**
San Francisco

You are invited to visit our Booths 38 and 39 in which we will display a Pet Milk plant in working miniature. This miniature plant has been displayed at many of the large medical meetings held throughout the United States. Competent men will be on hand to explain the processing of Pet Milk and many of our services to the physician will be available. Each person visiting our booths will receive a miniature Pet Milk can.

PHILIP MORRIS & COMPANY Ltd., Inc.
New York, New York **Booth No. 63**

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

PICKER X-RAY **Booth No. 8**
Los Angeles

Displayed will be the new Constellation tilt table with motor-driven spot film device. The Picker all-electronic 500 MA generator complete with all photo-timing attachments will be demonstrated.

RICHARDS MANUFACTURING COMPANY
Memphis, Tennessee **Booth No. 71**

Keeping in mind the fact that the Orthopedist and General Surgeon is at all times on the alert to find the most practical and efficient means of aiding him mechanically, we have, with the aid of many of these eminent men, devised, created and perfected a number of appliances which are in wide use today throughout the entire world.

We are at all times improving and perfecting new appliances and equipment.

In ordering equipment and supplies from Richards Manufacturing Co., you are assured of unexcelled craftsmanship and dependable service.

RIKER LABORATORIES, Inc. **Booth No. 83**
Los Angeles

The Riker Laboratories exhibit will feature Veriloid, a product of Riker research. Veriloid represents a potent alkaloidal fraction from Veratrum viride, biologically standardized for hypotensive activity in mammals. Veriloid represents a new active principle, not heretofore available, and useful in the treatment of all forms of hypertension.

A. H. ROBINS COMPANY, Inc. **Booth No. 57**
Richmond, Virginia

The A. H. Robins Company display is featuring the sedative-antispasmodic, DONNATAL; the antirheumatic, PABALATE; ENTOZYME, digestant with the unique "peptomatic" action; ALLBEE WITH C, our high-potency "B" complex with ascorbic acid; and PHENAPHEN WITH CODEINE, our new analgesic. Robins Medical Service Representatives will welcome the privilege of discussing with physicians attending the meeting these and other products in the company's line of prescription specialties.

J. B. ROERIG & COMPANY **Booth No. 74**
Chicago, Illinois

J. B. Roerig & Company will display their newest preparation, Am Plus, for treatment of obesity, and Viterra capsules, a complete nutritional supplement offering nine vitamins in combination with twelve minerals and trace elements. You are cordially invited to drop by and discuss your problems with our trained representatives.

SANBORN COMPANY **Booth No. 61**
Cambridge, Massachusetts

Visitors at the Sanborn Company booth, No. 61, will have the opportunity for acquaintance with the "Viso family" of direct-writing recorders for diagnosis, teaching, and research: the famous Viso-Cardiette, leader among direct-writing electrocardiographs; the Viso Recorder, for single channel recording without electrocardiography; and the Twin and Poly-Visos, for two- and four-channel recording of a wide variety of biophysical phenomena.

Also on display will be such useful supplementary instruments as the Sanborn Electromanometer and Ballistocardiograph; and attachments for registration of heart sounds (for timing), pulse waves, and pneumograms.

For the clinician interested in metabolism testing, the display will also feature the Sanborn Metabulator, with its revolutionary "all enclosed" design and "table-top" operation.

SANDOZ PHARMACEUTICALS **Booth No. 87**
San Francisco

This display will feature Cafergot (Cafergone), for the oral treatment of migraine and other types of headache; DHE-45 (Dihydroergotamine) for the parenteral treatment of migraine; Mesantoin and Hydantal for the treatment of epilepsy; Methergine, an oxytocic; and several cardiac glycosides including Cedilanid, Digilanid and Strophosid.

Well informed attendants will be present to answer all inquiries and to discuss new products to be released in the near future.

W. B. SAUNDERS COMPANY **Booth No. 1**
Philadelphia, Pennsylvania

We invite all doctors attending the meeting of the California Medical Association to visit our exhibit where Mr. J. Keith Chrysler will display a complete line of our books including Hyman's *Integrated Practice of Medicine*, Hyman's (new) *Progress Volume*, Bockus' *Postgraduate Gastro-enterology*, Conn's *1951 Current Therapy*, Sodeman's *Pathologic Physiology*, Anson's *Atlas of Human Anatomy*, Shanks' *Textbook of X-ray Diagnosis*, Colonna's *Regional Orthopedic Surgery*, Jackson's *Bronchoesophagology*, Sunderman and Boerner's *Normal Values in Clinical Medicine*, Hollinshead's *Functional Anatomy of the Limbs and Back*, Sweet's *Thoracic Surgery*, Smith's *Plastic and Reconstructive Surgery*, Moore's (new second edition) *Textbook of Pathology*, Major's (new fourth edition) *Physical Diagnosis*, Levine's (new fourth edition) *Clinical Heart Disease*, and many other new books and new editions.

R. L. SCHERER COMPANY **Booth No. 44**
Los Angeles

The R. L. Scherer Company will feature in their exhibit the latest in x-ray equipment as manufactured by the F. Mattern Mfg. Co. In addition to the x-ray many new items of interest to the medical profession will be shown, among them being an Electrocardiograph, short wave Diathermy, and Photoelectric Colorimeter.

The R. L. Scherer Company extends a cordial invitation to the members of the California Medical Association and their guests to visit their booth.

SCHERING CORPORATION **Booth No. 15**
Bloomfield, New Jersey

Sulamyd (Sulfacetimide Schering) will be featured at the exhibit. From a pharmacological and toxicological standpoint, Sulamyd deserves preference over other sulfonamides now in use for the treatment of infections of the urinary tract.

Trimeton and *Chlor-Trimeton*, two outstanding antihistamines, and *Coricidin*, Schering's new treatment for the common cold, containing Chlor-Trimeton, aspirin, phenacetin, and caffeine, will highlight the exhibit.

Schering Representatives will be present to welcome you, and will be happy to answer inquiries concerning Schering's new products as well as hormone, x-ray diagnostic, chemotherapeutic, and pharmaceutical specialties.

JULIUS SCHMID, Inc. **Booth No. 95**
New York, New York

Ramses Vaginal Jelly will be featured in demonstrations by representatives. Also will be shown the Ramses Physician's Prescription Packet No. 701, Tuk-A-Way Kit.

G. D. SEARLE & CO. **Booth No. 36**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Banthine, the true anticholinergic drug for the treatment of Peptic Ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed.

Other time-proven products of Searle Research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

SHARP & DOHME, Incorporated **Booth No. 33**
Philadelphia, Pennsylvania

Clinical data from the laboratories of the Medical Research Division of Sharp & Dohme are featured in Booth 33. The potentiating effect of a combination of the antibiotics, bacitracin and tyrothricin; the synergistic effect of penicillin in conjunction with the sulfonamides; and the use of Blood Group Specific Substances A and B in conditioning Group O blood, are of major interest.

THE SMITH-DORSEY COMPANY **Booth No. 62**
Lincoln, Nebraska

Smith-Dorsey is featuring: Doraxamin, an improved treatment for Peptic Ulcer; Dorantamin, a well-tolerated antihistaminic; Dorsaphyllin, a buffered Aminophylline possessing better gastric tolerance, and many Council-Accepted injectables. You are cordially invited to make the Smith-Dorsey booth your headquarters.

SMITH, KLINE & FRENCH LABORATORIES
Philadelphia, Pennsylvania **Booth No. 19**

'RESODEC'—'Resodec' is a revolutionary new development in the management of congestive heart failure. This remarkable substance produces the effect of cutting the patient's salt intake approximately in half. It does this by removing sodium from the contents of the intestinal tract and carrying it out of the body in the feces.

Thus, 'Resodec' not only gives you a positive means of achieving *adequate* sodium control—but also frequently allows your patients greater leeway in selecting foods.

E. R. SQUIBB & SONS **Booth No. 53**
New York, New York

E. R. Squibb & Sons look forward to seeing you at the California Medical Association meeting.

In support of the active scientific program which has been arranged you will find the Squibb representative glad to discuss all relative products. Also, for your convenience, selected professional literature will be available which you may take or request us to mail to your home.

Please visit the Squibb booth.

J. W. STACEY, Inc. **Booth No. 90**
San Francisco

Stacey's, established over a quarter of a century ago by members of the medical profession, provides the doctor in the West with an efficient source for all medical books of all publishers.

At Booth 90 you will find displayed the latest books on medicine, surgery and the specialties. You are cordially invited to browse at your leisure.

STAYNER CORPORATION **Booth No. 84**
Berkeley

We will feature newest development in barbiturate *withdrawal* therapy—two capsules identical in all physical appearances, size, shape and color, to two widely prescribed capsules which contain 1½ grains of barbiturates. Stayner will also feature their specially developed water soluble "D.A.S." (Dextro-Amphetamine Sulfate) 5 mg. tablets which dissolve in less than a minute. Several other of the 125 pharmaceutical and vitamin products manufactured will also be featured.

THE STUART COMPANY **Booth No. 92**
Pasadena

The Stuart Company offers nutritional products (liquid, tablet and capsule multivitamins; liquid and tablet hematinics; amino acids, tablet and powder form) supplemental and therapeutic. These can help simplify nutritional prescriptions—simply remember the name Stuart and the therapy needed.

UNITED LABORATORIES, Ltd. **Booth No. 72**
Pasadena

United Laboratories feature the results of clinical investigations on Actrope (ACTH) in varied disease conditions, including rheumatic fever, rheumatoid arthritis, lupus erythematosus, hypersensitivities, acute inflammatory diseases of the eye and skin, etc.

Other United specialties displayed include Lipo-B, Tropit (pituitary gonadotropins), Barbeloid and other outstanding prescription products.

A hearty welcome is issued to all members of the California Medical Association to visit the United exhibit.

U. S. VITAMIN CORPORATION **Booth No. 23**
New York, New York

See and taste for yourself the new and different sodium-free salt substitute—CO-SALT—which actually tastes like salt, looks like salt and sprinkles like salt—a great boon to your patients on restricted sodium intake.

Oil-in-water display demonstrates water solutions of oil-soluble vitamins, as exemplified by Aquasol Vitamin A Drops—first and only aqueous vitamin A preparation accepted by the Council on Pharmacy and Chemistry of the A.M.A.

VAISEY-BRISTOL SHOE CO., Inc. **Booth No. 70**
Rochester, New York

We will have on display in our booth a variety of styles of our Jumping Jack shoes. Stop in and discuss with our representatives your problems for the child from six months to four years.

VARICK PHARMACAL CO., Inc. **Booth No. 6**
New York, New York

Digitaline Nativelle, chief active principle of digitalis purpurea, is featured in a comprehensive exhibit of the Varick Pharmacal Company of New York. This world-renowned cardiotonic—the first of the digitoxins—has become especially favored because of its more complete absorption and its uniform rate of dissipation which enable it to maintain the maximum efficiency obtainable.

Shown in conjunction with the above is the new sodium- and lithium-free salt substitute, Diasal, which so remarkably duplicates the taste and texture of salt. Diasal, for patients on low-sodium diets, helps restore flavor to bland, saltless foods and keeps dieters on their diets.

WALKER VITAMIN PRODUCTS, Inc.
Mount Vernon, New York **Booth No. 58**

MENSALIN will be featured at the Walker exhibit. This new product, consisting of pyranisamine bromotheophyllinate, 50 mg. per tablet, is used in relieving premenstrual tension. By reducing the natural molimina, the distressing symptoms of nervous tension, breast tenderness, abdominal distention and pain are alleviated or precluded.

WALTERS SURGICAL COMPANY **Booth No. 43**
Los Angeles

We will show the latest H. G. Fischer Spacesaver X-ray, their FCC-approved Diathermy, and the Electro Physical Laboratories' electrocardiograph, the Cardiatron. Also a new style cabinet sterilizer by Pelton & Crane with their LV Autoclave, Combination Autoclave and Sterilizer combination No. 61 THP, and the E & O Light.

WESTWOOD PHARMACEUTICALS
Buffalo, New York **Booth No. 25**

Through its West Coast agents, Obergfel Brothers, Westwood will welcome inquiries about Westhiazole, Gentia-Jel and Lowila. May we demonstrate the convenience of the single dose, disposable applicator method of gentian violet treatment in the vaginal moniliases? Now the patient can apply gentian violet at home with a minimum of messiness.

WHITE LABORATORIES, Inc. **Booth No. 32**
Newark, New Jersey

On display will be Mol-Iron—clinically proved the most effective iron therapy known—available tablets and liquid. Courteous Medical Service Representatives in attendance will be happy to answer all questions and inquiries.

WINTHROP-STEARNS, Inc. **Booth No. 86**
New York, New York

Winthrop-Stearns, Inc., New York, extends a cordial invitation to visit Booth 86, where representatives will be on hand to discuss the latest pharmaceutical preparations made by this firm. Featured will be THENFADIL, a new and better antihistaminic which is exceptionally effective in bronchial asthma (82 per cent) as well as other common allergic disorders; SULFAMYLON, new sulfonamide for topical use with wide antibacterial range (including anaerobes, gas gangrene); not inhibited by pus. Available as 1 per cent solution, and as 5 per cent solution in combination with Streptomycin (20,000 units); MILIBIS, new, virtually non-toxic amebacide; ARALEN, the modern colorless antimalarial specific.

WYETH, Incorporated **Booth No. 82**
Philadelphia, Pennsylvania

Wyeth, Incorporated, will feature SMA, the "proven prototype" of prepared infant food formulas. Trained representatives will be pleased to discuss the flexibility of SMA—permits the creation of the most precise, individualized formulas. To be co-featured with SMA is the TUBEX System of convenient, safe, ready-to-use injectables. This unique system makes available for immediate, sterile injection diagnostic and therapeutic allergen preparations, hormones, tetanus antitoxin, various forms and concentrations of penicillin in both oil and aqueous suspensions and dihydrostreptomycin—all in TUBEX. Representatives will be present to discuss these and other Wyeth products. Samples and literature will also be available.

PRE-CONVENTION REPORTS

Officers - Councilors - Committees - County Societies

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the Members of the California Medical Association and the House of Delegates:

Your President has been very active in our campaign to reach the grass roots Doctors in the state in a program of education. We have attended many county meetings and it has been exceedingly refreshing to find that your President has received such courtesy, deference, and such good attendance both from the county medical societies and from the county medical woman's auxiliaries.

I am sure that our efforts have been reflected in the welcome news that we got from the election last November.

The California Medical Association has become an aggressive, intelligent, powerful group engaged in spreading information relative to public health and personal health problems. In fact, the California Medical Association is accepted as one of the leading progressive medical societies of all the states.

It has been a great pleasure and honor to have served as President, and I am sure that all will realize that the President himself is a very small cog in the machinery of the administration of your affairs. The greatest credit should be given to the Council, the Executive Committee of the Council, the various standing committees of the California Medical Association, and to the House of Delegates itself for the responsibility of producing the progressive leadership that California has attained.

I have attended all of the Council meetings, all of the Executive Committee meetings, except those in which I was away on either A.M.A. business or other excusable absences. The cooperation of all of the California medical societies has been better than excellent. We can look forward to continuing years of successful leadership as long as we have the type of Doctors serving on our councils and committees as we have in the present.

Respectfully submitted,

DONALD CASS, *President*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

Your President-elect has assisted the President in carrying out the functions of his office.

In association with Mr. John Hunton, Executive Secretary of the C.M.A., meetings were held with 25 county medical associations in Northern California. At some of these, Mr. Ben Read, executive secretary of the Public Health League of California, participated. The importance of the individual doctor-patient relationship as part of medical public relations was stressed. The attendance at these meetings and interest shown in the C.M.A. was excellent. The high regard for our Executive Secretary and Mr. Ben Read was noted with great satisfaction.

Meetings were held with several woman's auxiliaries to county medical associations, and with the officers of the Woman's Auxiliary to the C.M.A. The effort put forth and the intense interest shown by these groups in Association affairs was truly remarkable. We can be proud of our woman's auxiliaries.

All the meetings of the Council were attended and an active part was taken on various committees of the Council.

The hospitable and kindly reception given by county medical associations and woman's auxiliaries was greatly appreciated and is hereby warmly acknowledged.

Respectfully submitted,

H. GORDON MACLEAN, *President-Elect*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

"Security is a transient state of relative safety, an alert maneuver in a constantly moving area of danger.

"It is not an ultimate destination where all is serene. It can be seized and held from one fleeting moment to the next only by constant application of imaginative skills."—Mayo Shattuck.

While this quotation is taken from an address by Mayo Shattuck, a distinguished attorney and authority on estate planning, before the Mid-winter Trust Conference, urging mobility and flexibility in trust agreements, the basic ideas expressed seem particularly applicable to the activities of the House of Delegates and of those to whom it delegates authority to act on its behalf.

The House of Delegates is the policy-making body of the California Medical Association. As such, its interests are broad and comprehensive, involving as they do an insistence upon a constant elevation of the scientific standards of medical care, a consideration of the manner in which that care is rendered, of those who render it, and of their contacts with each other and with those who participate in any manner in the attack upon ill health and its physical and economic consequences, as well as an intelligent and discerning regard for the milieu in which medicine and its ancillary sciences are practiced.

An important function of any professional organization is the protection of its members in the pursuit of their calling so long as that pursuit does not impinge upon the public interest. The House of Delegates has demonstrated an awareness of changing concepts in the practice of medicine and in the public attitude toward it, and an ability to devise new methods in keeping with modern ideas but at the same time conserving fundamental principles established by past experience. This has been well evidenced in the organization of California Physicians' Service and the careful supervision of that plan by the members of the House of Delegates acting in their alter ego as the administrative members of California Physicians' Service. At the San Diego session, a special liaison committee of the Association was created by order of the House in order to work more closely with Cali-

fornia Physicians' Service and to reflect in the activities of that organization more accurately the wishes of every member of the California Medical Association.

Between sessions of the House of Delegates, the Council, and in turn the Executive Committee are directed by the House to perform certain functions for it, always subject to review by the parent body. Special committees of the House and of the Council are authorized with specific functions to perform as the need arises, and these in turn bring to the deliberations of the parent body the best of the Association's talent and contribute the essential information upon which to base decisions.

Every action by the House of Delegates, the Council, or the Executive Committee, dealing in any manner with the law of the state or the nation is referred to legal counsel for study and advice.

Organized Medicine, like any other structure, is in constant need of new blood, new energy, and new ideas. There is a place in its many phases for every Association member who is genuinely interested in the broad economic, political, and social welfare of his profession, and who is willing to devote a considerable portion of his time and energy in its service. If the actions of your House of Delegates do not always meet with your approval, let every member of the Association realize that these result only after a most thorough consideration by committees and upon unlimited debate before the House. Every member of the Association is urged to attend meetings of the House of Delegates and to present his ideas on resolutions under consideration by the reference committees.

"Security is but an illusion; repose is not the destiny of man."—Oliver Wendell Holmes.

Respectfully submitted,

L. A. ALESEN, *Speaker*

REPORT OF THE VICE-SPEAKER

To the President and the House of Delegates:

The Vice-Speaker has attended the meetings of the Council and has carried out such assignments as have been delegated by the Council and its officers.

Respectfully submitted,

DONALD A. CHARNOCK, *Vice-Speaker*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

During the current year the Council has met regularly as reported in CALIFORNIA MEDICINE. A perusal of the minutes has acquainted most of you with the problems which have arisen during the course of the year and with the efforts of the Council to find the proper solution.

You will note that as a rule mornings have been devoted to committee reports and business of a routine nature, the lunch period to hearing representatives of business and other groups who wished to appear before the Council, and afternoons to the consideration of new problems which have claimed the attention of the Council. While it has not been possible to follow this schedule completely, it is the overall pattern which has been followed in the current year.

Everyone who wished to appear at a Council meeting has been permitted to do so. Dr. Halverson or one of his representatives has again appeared regularly to continue the productive liaison which has been developed with the State Department of Public Health. Both the Council members and the official personnel of the various county medical societies have been regular in attendance.

Dr. Murray, chairman of the Legislative Committee, Mr. Hassard, our attorney, and Mr. Ben Read and John Hunton have been invaluable to the Council. I am sure they understand that their efforts have been appreciated.

Respectfully submitted,

SIDNEY J. SHIPMAN,
Chairman of the Council

REPORT OF THE VICE-CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

As Vice-Chairman of the Council I have attended all the meetings of the Council, and have aided the Chairman whenever any assistance was requested.

Respectfully submitted,

DONALD D. LUM,
Vice-Chairman of the Council

Report of the Council

To the President and the House of Delegates:

The Council of the California Medical Association has held five meetings since the close of the 1950 Annual Session. These were held on May 3, May 27, September 9 and November 5, 1950, and January 27 and 28, 1951. An additional meeting will be scheduled prior to the convening of the 1951 Annual Session.

In addition, the Executive Committee has held four meetings in this same period and its deliberations have been reviewed by the Council and printed as a part of the Council minutes in the next available issue of the Journal.

The policy of alternating Council meetings between San Francisco and Los Angeles has been continued, for the convenience of all concerned.

The Council herewith presents a digest of some of its more important items of consideration during the past year.

1. *Organization:*

Attention is called to the reports of the Secretary, Treasurer, Editor, Legal Counsel and Executive Secretary, published elsewhere in this issue. Each of these representatives has been called upon for service under the jurisdiction of the Council and has reported regularly to the Council on his activities. Each report is subject to approval, amendment, additions, deletions or corrections and the Council has reviewed each with due diligence.

2. *Membership:*

The membership of the Association at the close of 1950 totaled 10,638 active and associate members, the latter classification accounting for 142 of the total. This membership places the California Medical Association as second largest state organization in the American Medical Association, surpassed only by New York state. On the basis of this membership, the Association has been entitled to eleven Delegates in the American Medical Association and has been represented by that number in the June and December, 1950, meetings of the A.M.A. House of Delegates. Attention is called to the fact that A.M.A. representation will henceforth be based on one Delegate to each 1,000 *active, dues-paying members of the A.M.A.*, or fraction thereof. Inasmuch as about 800 members of the Association had not paid their A.M.A. dues prior to December 1, 1950, when the A.M.A. official membership count was taken, California will probably lose one A.M.A. Delegate in the 1951 A.M.A. meetings.

The delinquency of C.M.A. members in paying A.M.A. dues results primarily from delayed billing procedures used in some county medical societies in the state, which billed

their members for A.M.A. dues only after they had paid their county and state dues. It is believed that this situation will not exist in 1951 and that this delinquency, roughly 8 per cent, will be eliminated from now on. As it is, California stands very high in the A.M.A. dues-collection list and will likely represent an even larger proportion of the A.M.A. House of Delegates in 1951 than it has heretofore.

At the close of 1950, only 147 members of the Association, or less than 1½ per cent, had failed to pay their C.M.A. dues. Most of these are members who have moved to other locations and have not notified the Association of their transfers.

3. *Special Committees:*

In addition to the standing committees of the Association, the Council has from time to time appointed special committees to handle specific problems and to serve as continuing bodies which may become expert in particular fields. Without in any way failing to recognize the work of all such committees, the Council wishes to call especial attention to the work of several of these committees, including the following:

Committee on Industrial Accident Commission: This committee has met with its own members, the members of its advisory committee of specialists and with representatives of the compensation insurance industry, in an effort to evolve a suitable schedule of fees and instructions for the proper and compensable handling of industrial injury cases. The committee has reported regularly to the Council, which is pleased to recognize here the excellent work which has already been accomplished and which is now in prospect. It is believed that much good will come from the activities of this group.

Committee on Public Health and Public Agencies: This committee has maintained a steady liaison with state and local health officers and with public groups operating in the field of the care of the public for various ailments. Through its activities it has been able to provide wise counsel to various bodies in matters pertaining to hospital construction and operation, poliomyelitis, tuberculosis, heart disease, public health and related topics. Its findings and recommendations have appeared in the printed Council minutes and have been made available to the Council regularly. The importance of this committee cannot be overemphasized.

Blood Bank Commission: As of the end of 1950, the Blood Bank Commission reports eight blood banks of the community type in operation, one more about to start and another in the planning stage. This is a long step toward fulfillment of the goal of 14 blood banks in a statewide system. The California Blood Bank Commission has received national recognition for its progressive program of establishing a statewide network of community non-profit blood banks designed to serve the civilian population of the entire state and to make their facilities available to the military forces in time of need. No other state has developed a comparable comprehensive program and the members of this commission are to be congratulated on their forward-looking activities.

During the year the Council has set aside $150,000 as a loan fund to blood banks starting up under this program, all loans to be issued without interest and to be repaid under a fiscal system acceptable to the borrowing blood bank. One capital loan to start a new blood bank has already been authorized and partially advanced, while smaller loans have been made to three blood banks for the purchase of bottles, tubing and other supplies to permit a stockpiling program for the protection of the armed forces.

Committee on Clinical Material for Teaching Hospitals: This committee has been studying the possibilities of admitting to teaching hospitals, as clinical material, selected cases where the patient is covered by some form of hospitalization insurance. It should be pointed out that the rapid spread of hospital insurance has made the acceptance of the required teaching cases much more difficult; if a program of accepting insured cases for teaching purposes can be worked out, the hospitals will gain not only the teaching material but also the financial support which many of them need as departments of medical schools. Studies by this committee are continuing and are expected to be most productive.

4. *Public Relations:*

During the past year the Council has carried out the orders of the House of Delegates in cancelling, as of the end of 1950, the radio program *California Caravan*. Decision on this step was made late in the year, at a time when both the Advisory Planning Committee and the Committee on Medical Economics were engaged in working toward a program of public relations based upon the individual physician-patient relationship. Public relations counsel are still employed on a retainer basis and the Association still has available professional talent and opinion in this important field.

5. *Public Policy and Legislation:*

In the department of public policy and legislation, the Council believes the Association is probably better represented at this than at any previous time in its history. Dr. Dwight H. Murray, legislative chairman, is ably assisted by Mr. Ben H. Read, Executive Secretary of the Public Health League of California, and Mr. Howard Hassard, legal counsel. Both of these men have done outstanding work in handling the Association's legislative affairs and the Council wishes to pay full tribute to them, as well as to Dr. Murray, for their outstanding accomplishments. The year 1951 is another legislative year and it appears at this writing that medicine faces some of the most extreme threats ever leveled at it, especially from irregular groups of practitioners. The Council realizes that it is not always possible to attain all the objectives of the profession but is confident that its legislative representatives will end the legislative session with an exceptionally high score.

6. *Antivivisection:*

During 1950 the Council approved funds to aid in opposing serious antivivisectional legislation in Los Angeles. By popular vote in November, the citizens of Los Angeles overwhelmingly approved a sound program of humane pound legislation sponsored by scientists. Mr. Ed Clancy, Field Secretary, managed the physicians' campaign in a most able manner and the thanks of the Council go to him. This recurring subject will doubtless be before either local or state voters in coming months and the experience in the Los Angeles campaign will stand the Association in good stead.

7. *Emergency Medical Service:*

The Council feels itself fortunate to have an able Committee on Emergency Medical Service working on this important topic. Recognition of the committee's work has come from the State of California, which has appointed Dr. Justin J. Stein to two important posts in the state's emergency set-up.

8. *Interns and Residents:*

During the past year the publication of the Committee on Interns and Residents has been given a new name, *Future M.D.*, and a new format and table of contents. Each bi-monthly issue is sent to all medical students, interns and residents in California and the publication has gained national recognition as a sound method of assisting young physicians in their transition from school or hospital to the realm of medical practice. The committee is deserving of full acclaim for its fine work.

9. *Student Nurse Recruitment:*

During 1950 the Council appropriated funds to assist the hospitals, nursing schools and other professional organiza-

tions in a campaign to secure greater interest in nursing schools for potential students. With a great need for nurses and with nursing school enrollments at a relatively low level, this project is considered extremely important. It is the hope of the Council that the organized effort to secure more student nurses will produce the desired result.

10. *California Physicians' Service:*

Through some duplication of membership and through open invitations for the Association and C.P.S. to be represented at each other's official meetings, a steady liaison with California Physicians' Service has been maintained. In addition, a special Council committee has recommended the appointment of a liaison committee to represent the officers of the Association, the Board of Trustees of C.P.S. and the House of Delegates. Although this committee cannot be fully activated until the next meeting of the House of Delegates, it has already been established on an informal basis and is now functioning in an unofficial manner.

11. *Legal Department:*

The Association continues to be excellently represented in legal matters by the firm of Peart, Baraty & Hassard, with Mr. Howard Hassard handling most C.M.A. matters in extremely competent fashion. Mr. Hassard is frequently called upon for services far beyond the normal role of legal counsel and is always prompt, thorough and sound in his judgments and decisions. On several occasions in the past year he has been authorized to appear for the Association in law cases involving principles of interest to the medical profession. Throughout the past year he has participated actively in the defense of one county medical society against allegations of restraint of trade in not electing to membership certain applicants whose applications did not receive favorable consideration. This case is similar to several other past and present anti-trust cases and it is hoped to have a decision on it some time this year.

12. *Medical Fees:*

The Council now has before it a proposal to enter into a scientific study of medical and surgical fees, with the thought of producing some sort of yardstick to serve as a recognized basis for establishing fees, especially in fields where governmental or other agencies are financially responsible. This proposal comes from the Committee on Industrial Accident Commission and from other sources as well, including one of the surveys made by the Committee on Medical Economics. Although no decision has been made on this subject, the Council believes it to be vitally important.

The Council recognizes the dangers, as well as the advantages, of establishing a schedule of fees and will give thorough consideration to all points of view. As a part of the over-all consideration of public relations, it appears that a proper schedule of average or minimum fees would offer a degree of consistency which would merit public approval and would furnish a uniform basis for various types of arrangements betwen the profession and public agencies.

13. *California Medicine:*

Again the Council wishes to express its warm approval of the extremely valuable handling of the official journal, CALIFORNIA MEDICINE, by Editor Dwight L. Wilbur and his staff. The journal continues to occupy a high place among publications of its type and grows in national acclaim. At the same time, it provides an ideal medium for the dissemination of Association news.

14. *Additional Report:*

In its meetings prior to the 1951 Annual Session the Council may develop additional items on which a supplemental report to the House of Delegates may be based. Such addenda, if forthcoming, will be presented at the opening session of the House.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Chairman*

REPORT OF THE PRESIDENT OF THE TRUSTEES OF THE C.M.A.

To the President and the House of Delegates:

Serving solely as a holding company, in corporate form, for assets of the California Medical Association, the Trustees of the California Medical Association is a non-profit corporation whose members are at all times the members of the C.M.A. Council. The corporation has met in accordance with its articles of incorporation and its by-laws during the past year and its financial report is printed elsewhere in this issue under the report of the Treasurer.

Respectfully submitted,

DONALD CASS, *President*

REPORT OF THE SECRETARY

To the President and the House of Delegates:

Your Secretary was appointed by the Executive Committee in August 1950 and confirmed by the Council in September. Since then he has attended the meetings of the Council and the Executive Committee.

He has presided at the meeting of the Committee on Scientific Work and at meetings of the section secretaries in arranging for the 1951 convention. In addition he has attended meetings of the Committee on Postgraduate Activities and other committees appointed by the House and Council.

The minutes of the Council meetings are prepared by the Executive Secretary, then edited by the Secretary, the Chairman of the Council and the Legal Counsel.

It is recommended that these be read in detail by all members.

Respectfully submitted,

ALBERT C. DANIELS, *Secretary*

REPORT OF LEGAL DEPARTMENT

To the President and the House of Delegates:

The Legal Department submits the following summary covering the nature of its activities during the year 1950 and up to the time of the preparation of this report, January, 1951:

During the past year we have attended all meetings of the Council and the Executive Committee, as well as various meetings of standing committees and other agencies of the Association.

We have also prepared and submitted opinions on a wide variety of subjects, as requested by the Association or its officers or component societies, including disciplinary procedural questions, questions of interpretation of the principles of medical ethics, legal problems connected with operation of blood banks, the relationship of corporations and other lay agencies to the practice of medicine, and a number of questions arising out of pending legislation or newly enacted laws.

In addition to our advisory services, we have also undertaken, at the instance of the Council, the following:

1. *Legislation:*

We have assisted the Committee on Public Policy and Legislation throughout the year. During 1950 we have appeared before and have followed the proceedings of three

legislative interim committees: The Assembly Interim Committee on Public Health, the Senate Interim Committee on Workmen's Compensation, and the Assembly Interim Committee on Finance and Insurance. All three of these committees have investigated public problems and submitted comprehensive reports to the Legislature that affect various phases of the practice of medicine.

At the present time, we are in the process of reading and analyzing over five thousand bills introduced early in January at the 1951 Regular Session of the Legislature. We anticipate that, as usual, there will be in the neighborhood of five hundred bills that directly affect the medical profession. The job of reading over five thousand bills is one that requires endless hours; however, the most difficult part is to ascertain exactly what each bill will do with respect to changing or modifying existing law. This requires constant reference to all of the statutes and court decisions in California that relate to the subject matter of each bill.

A year ago we reported that Congress had broken out with a rash of health insurance bills of all types and classifications, and that, in addition, there were a great number of other bills proposed in Congress affecting the medical profession, including subsidies of medical schools and medical education, extension of social security, etc. The current session of Congress is equally active in the field of medical care. Since Congress convened early in January 1951, practically all of the bills that were pending before it in 1950 have been reintroduced. The desire to use federal tax funds to subsidize, and ultimately bring under centralized federal control, state and local activities of all kinds, continues unabated.

2. *Malpractice Cases:*

As amici curiae, we appeared in an extremely important malpractice case decided by the California Supreme Court in the fall of 1950. The case is *Cavero vs. Franklin Hospital*, involving the death of a young child while under a general anesthetic and during the course of a tonsillectomy. In a five to two decision, the Supreme Court held that the fact of death standing alone was sufficient to invoke the doctrine of res ipsa loquitur. In legal theory, res ipsa loquitur (the thing speaks for itself) means, as applied to a malpractice case, that the plaintiff need only prove the happening of the event and that the case may ultimately be submitted to the jury without any expert testimony on behalf of the plaintiff tending to prove the defendant physician negligent. In practical application, res ipsa loquitur means that the defendant physician has the burden of establishing by expert testimony that he was not negligent; hence res ipsa loquitur reverses the ordinary conception that the plaintiff must prove his case by a preponderance of the evidence. Carelessly used or extended beyond its original concept, it can convert physicians and surgeons into guarantors of the results of their services, and have the inevitable effect of requiring all physicians and surgeons to take no action when there is any possible risk involved, to the irreparable injury of the public. Hence, any extension of the doctrine of res ipsa loquitur is of tremendous public as well as professional interest.

Prior to the Cavero case, we were of the opinion that the mere fact of death under circumstances that rarely result in death, was not sufficient to put the burden of proof on the attending physician or operating surgeon. It is our opinion that all of the following conditions must exist before res ipsa loquitur should be applied:

1. The defendant must have exclusive possession or control of the instrumentality causing the injury;

2. The accident must be of such a character that in the ordinary course of events it would not be expected to occur if due care had been used by the defendant;

3. The accident must have occurred without any voluntary action or participation by the party injured; and

4. The information as to the cause of the accident must be more accessible to the defendant than to the plaintiff.

However, in the Cavero case, a majority of the supreme court held that the fact that deaths rarely occur during tonsillectomies was sufficient to apply res ipsa loquitur and to require the defendants, a surgeon and a hospital, to explain and to prove lack of negligence. A minority of the court dissented, on the ground that the mere fact that death under such circumstances was rare was insufficient to apply res ipsa loquitur, and pointed out that a decade ago, in *Engelking v. Carlson*, the same court had held that res ipsa loquitur was not applicable to the severance of the peroneal nerve during a knee operation, merely because such a severance was a rare occurrence.

It is too soon to foretell what effect the Cavero decision will have upon malpractice cases in California. If the opinion of the majority of the court is carried to its logical conclusion, physicians and surgeons will be required to prove themselves innocent whenever death occurs under circumstances that infrequently result in death, or where any unusual result occurs. This would be so incompatible with a vigorous medical profession, and would be so injurious to the public, that we cannot but believe that the supreme court will in future cases clarify and modify its views.

3. *Constitution and By-Laws:*

We assisted in drafting the proposed new constitution that will be voted on by the House of Delegates at the 1951 session and the proposed by-laws that will be presented to the House of Delegates at that time. The constitution and by-laws that will be presented to the 1951 session are the result of drafting and redrafting over a period of several years.

There have been other services performed by the Legal Department which will be reported orally to the House of Delegates.

As we have concluded our report in previous years, "We wish to reiterate our constant desire to serve the medical profession to the best of our ability."

Respectfully submitted,

PEART, BARATY & HASSARD,
General Counsel

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your Executive Secretary herewith submits his report for the past year in subdivisions for greater clarity.

1. *General:* The Association office occupies the same space as a year ago, although some alterations are now under way to provide more wall space for the maintenance of record files. Each increase in the membership of the Association—and the membership has shown a consistent increase in each of the past ten years—means that more individual and group records must be kept. This means new equipment and demands that additional space be arranged for and obsolete and useless material be constantly weeded from the files.

The files are currently in excellent condition and free of deadwood. Additional units now being installed are designed to keep them that way.

As to office equipment, two new typewriters have recently been purchased under a planned system of rotation of machines in order to keep this equipment as modern as possible without adding undue burdens to the budget. Under existing threats of material shortages, rationing and similar wartime measures, it is essential to keep such equipment in good condition.

It should be pointed out that the Association's office is daily getting closer to the point at which it cannot, in its present space, adequately serve the needs of the organization in an efficient manner. A year ago it was believed possible to secure some additional office space but this prospect did not materialize. Before too long it will doubtless become necessary to work out a complete overhaul of the office situation, whether it be through additional space at the same location, extensive alterations or new and larger space in some other place. This is not a matter of immediate concern but advance planning demands that this eventuality be kept in mind.

2. *Meetings:* The Executive Secretary has attended all meetings of the Council and the Executive Committee, together with a number of meetings of standing and special committees. He has also attended a number of informal meetings with officers of the Association and has served as an aide to the Association's delegates to the regular and interim meetings of the American Medical Association. In addition to these, he has attended, as a guest speaker, the meetings of 27 county medical societies during the fall months. Mention of these visits will be made under the heading of public relations.

3. *Financial:* Reports of the financial status of the Association at the close of its 1950 fiscal year will be found under the report of the Treasurer, representing the reports of the certified public accountant who audits the C.M.A. books. As the employee directly responsible for the handling of finances, the Executive Secretary offers a few items of interest.

The Association closed its 1950 fiscal year in excellent financial condition. Its revenues for the fiscal year ended June 30, 1950, totaled $580,314, or $91,623 more than its expenses for the same period. From this surplus and other funds it was possible to transfer $100,000 in U. S. Treasury Bonds to the Trustees of the California Medical Association, the corporate non-profit affiliated organization. Expenditures in all major divisions of the budget, namely, administrative, scientific-educational-and public relations, and the official journal, were within budgeted figures, and revenues were higher than the budget.

Expenses of the Southern California office, of the Stockton office of the Committee on Postgraduate Activities and of the Cancer Commission office in San Francisco were all within their budgets. The official journal returned a sizable net profit, as will be shown in another section of this report.

The Trustees of the California Medical Association, as shown in the financial report of the corporation, showed a gain in surplus and in investment funds at the close of the 1950 fiscal year. This corporation serves only as a holding company for accumulated assets and its business transactions consist entirely of the buying and selling of securities. Its report is listed under the report of the Treasurer.

4. *California Medicine:* The Association again has every right to feel pride in its official journal. Under the present editorial policy it has gained an enviable position among state medical journals, has provided an ever-growing service to members of the Association in publishing current medical articles and has, at the same time, carried its own weight and returned a financial profit. For the 1950 fiscal year the journal showed revenues of $121,813 and expenses of $101,402 for a net profit of $20,411. This accounting is based upon the payment of rent for the office space used, payment of applicable salaries and assumption of all expenses on a cost-accounting basis. Included in the audited income is the subscription rate of $3 per year per active member of the Association, in accordance with postal requirements.

The journal is indebted to its Committee on Advertising, appointed by the Council several years ago to screen advertising offerings. This committee meets frequently, diligently reviews every word of advertising copy under consideration and accepts or rejects every advertising item. This is a task of large proportions and the members of this committee are entitled to a vote of thanks for their interest, diligence and high standard of performance.

5. *Public Policy and Legislation:* The Executive Secretary is again being called upon by the Committee on Public Policy and Legislation to aid in the legislative activities of the Association. This work involves giving testimony before standing or interim committees of the Legislature, as well as cooperating with committee members and legislative representatives in the numerous duties of the committee. The 1951 legislative session promises to be even more important than other recent sessions and the Association's office will be ready to do what is required to aid in this important activity.

6. *Public Relations:* The Executive Secretary has worked in the past year on a proposed program of public relations, to emanate from within the Association. This work has been carried on under the Advisory Planning Committee and to date the plans have met with approval, in principle, by the Council. The underlying feature of the proposed program is the bringing home of the individual physician's responsibility in the field of public relations and the establishment of progressive programs at the county level to assure good public reception. At this writing the program is still in preparation but upon its completion and activation it will represent a distinct tie-in between the Association, its component county societies and the individual members.

During the fall months the Executive Secretary accompanied the President-elect, and on two occasions the President, on visits to 27 county medical societies. The purpose of these visits was to bring home to the individual physicians their own responsibilities in public relations and to suggest ways and means of meeting those responsibilities. It is hoped that these visits may have represented the first step in paving the way for general acceptance of the public relations program mentioned above, in alerting individual members to the manner in which they can contribute to the good of the entire profession. The visits to the county medical societies have taken considerable time and have required a great deal of travel; at the same time, it is believed that the personal contact between the officers of the Association and the component county societies has been well worth every effort required. Such meetings bring the state and county organizations closer together and should be continued as assets of incalculable value.

7. *Annual Session:* Plans for the 1951 Annual Session are well under way at this time and a most successful meeting is anticipated. Unfortunately, color television showings of surgery and medical clinics could not be secured because of space limitations, but it is hoped to have that feature available at future meetings. The coming meeting appears to be the largest ever planned by the Association, both in terms of exhibits and of scientific papers scheduled. Every effort will be made to provide a smooth operation of the entire session; in this connection the Committee on Scientific Work has been most cooperative and willing to attend to the many details which are beyond the capacity of a small central office staff to handle.

8. *Conclusion:* The Executive Secretary wishes to express his profound thanks to the Officers and Councilors of the Association for their constant and ready cooperation in all matters. The Association's office is maintained to relieve these busy practitioners of all possible responsibilities, while at the same time carrying out their directives. The ready availability of all these men makes it possible to put official policies into effect with a minimum of delay. The Editor and

Secretary-Treasurer have also been most cooperative at all times and of invaluable counsel. Legal counsel, the field secretary and the executive secretary of the Public Health League of California have all been unsparing in their assistance throughout the year and special thanks are due them. The office staff has, as usual, carried out its duties in a prompt and competent fashion and has made it possible for the Association's work to go forward. The cooperative spirit of the staff members is a daily inspiration and cannot be too highly praised.

Respectfully submitted,

JOHN HUNTON, *Executive Secretary*

REPORT OF THE EDITOR

To the President and the House of Delegates:

Continuing effort was made last year to make CALIFORNIA MEDICINE representative of the various facets of the practice of medicine in the state. To that end, careful consideration was given to manuscripts originating outside as well as from within the metropolitan and teaching centers. In the interest of a well rounded journal, a number of articles considered worthy of publication were reluctantly returned to the authors because CALIFORNIA MEDICINE already had on hand a sufficient stock of articles dealing with subjects in the same field of medicine.

As a considerable number of the letters directed to your journal concern the date of publication of one or another of the articles that have been accepted, explanation of publication schedules is in order. A large part of the material for CALIFORNIA MEDICINE is made up of papers read at the Annual Session of the California Medical Association. Most of those accepted are accepted within a relatively short period after the meeting. This creates a bulge in inventory which can be but slowly reduced. Meanwhile and throughout the remaining months of the year, manuscripts sent directly from other sources are being accepted. In selecting material for publication in each issue of CALIFORNIA MEDICINE, consideration is given to timeliness and to a balance of content as between the sources and the subject matter of the articles. Because of these factors, some articles are used soon after they are accepted, others not until many months have elapsed. Not infrequently, delay in publication is caused by necessity of correspondence with the authors of manuscripts regarding questions raised and revisions suggested by members of the Editorial Board.

During the past year the average interval between acceptance and publication of articles was five months. In order to keep that interval as short as possible, a reduction in inventory was effected by publishing more articles than were accepted during the year. Of 293 articles submitted, 148 were accepted. The number printed was 162.

The annual report of the Editor of your journal gives him welcome opportunity to express an accumulation of gratitude to the members of the Editorial Board, who by careful appraisal and criticism of manuscripts submitted have made his duties the lighter. Thanks are also due to Robert Edwards, assistant to the Editor, who has continued to render invaluable service in every capacity in the production of the journal, and to John Hunton, Executive Secretary, who has written many of the editorials. To others, too—to those who have prepared special material for the journal, to those who have written book reviews, to those who because of specialized knowledge have been called upon for opinion of manuscripts, and to the office staff of CALIFORNIA MEDICINE—to them the editor's thanks.

Respectfully submitted,

DWIGHT L. WILBUR, *Editor*

REPORT OF THE TREASURER

To the President and the House of Delegates:

The Treasurer of the Association was appointed in August. The actual duties of this office are performed by the office staff and the accounts are audited by an independent accounting firm. The receipts and expenditures of all funds are checked and the presence of cash, securities and other assets is certified to.

Submitted herewith is the series of accounts prepared by John F. Forbes and Company covering the fiscal year July 1, 1949 to June 30, 1950.

Members are urged to study the accounts for a true picture of the Association's financial position.

Respectfully submitted,

ALBERT C. DANIELS, *Treasurer*

(Balance sheets and statements of income and expenditure appear on following pages.)

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

(A California Corporation)

BALANCE SHEET, JUNE 30, 1950

ASSETS

CASH (Exclusive of Benevolence and Endowment Funds)			$ 22,963.18
INVESTMENTS (Exclusive of Benevolence Fund Investments)			1,003,000.00
BENEVOLENCE FUND (Including Investments in U. S. Government Bonds) (Contra)			26,186.37
ENDOWMENT FUND (Contra)			276.74
TOTAL ASSETS			$1,052,426.29

LIABILITIES

DUE TO BENEVOLENCE FUND			$ 165.00
BENEVOLENCE FUND (Principal Plus Income Accumulation) (Contra)			26,186.37
MEMBERS' CONTRIBUTION TO ENDOWMENT FUND (Principal Plus Income Accumulation) (Contra)			276.74
SURPLUS:			
Contributed Surplus:			
Balance, June 30, 1949	$781,775.28		
California Medical Association—Bonds and Accrued Interest	101,140.71		
Total		$882,915.99	
Earned Surplus:			
Balance, June 30, 1949	$119,850.89		
Net Income for Year	23,031.30	142,882.19	
Total			1,025,798.18
TOTAL LIABILITIES			$1,052,426.29

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

San Francisco, California

STATEMENT OF INCOME

For the Year Ended June 30, 1950

INCOME:		
Interest on Bonds		$ 23,756.93
Interest on Savings Account		2.87
TOTAL INCOME		$ 23,759.80
EXPENDITURES:		
Premium on Bonds Purchased	$487.50	
Audit Fee	210.00	
Miscellaneous	31.00	
TOTAL EXPENDITURES		728.50
NET INCOME		$ 23,031.30

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, California

BALANCE SHEET—JUNE 30, 1950

ASSETS

CASH		$ 84,328.66
ACCOUNTS RECEIVABLE:		
California Medicine Advertisers	$ 1,605.17	
Less Reserve for Doubtful Accounts	500.00	
Remainder	$ 1,105.17	
Other	1,031.21	
Total		2,136.38
LOAN RECEIVABLE—NEW MEXICO PHYSICIANS' SERVICE	$15,500.00	
Less Reserves	14,500.00	
Remainder		1,000.00
INVESTMENT IN U. S. TREASURY BILLS (at cost)		299,353.40
CASH SURRENDER VALUE OF LIFE INSURANCE POLICY		2,211.60
TRUST FUNDS (contra)		17,247.90
FURNITURE AND FIXTURES (at nominal value)		1.00
DEFERRED CHARGES		20,687.47
DEPOSITS		974.88
TOTAL		$427,941.29

LIABILITIES

ACCOUNTS PAYABLE:		
American Medical Association	$ 2,450.00	
County Societies	1,150.00	
Taxes collected for Federal Government from Employees	875.84	
Miscellaneous	985.90	
Total		$ 5,461.74
ACCRUED EXPENSES:		
American Medical Association—Delegates' and other expenses	$ 4,010.93	
Committees' and Sundry	3,108.46	
Pay Roll Taxes	255.36	
Total		7,374.75
TRUST ACCOUNTS (contra)		17,247.90
DEFERRED INCOME—PREPAID ADVERTISING		229.68
SURPLUS		397,627.22
TOTAL		$427,941.29

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

STATEMENT OF INCOME AND SURPLUS
For the Year Ended June 30, 1950

INCOME

DUES AND GENERAL:		
Membership Dues, less portion allocated to *California Medicine* Subscription		$438,208.68
Exhibitors at Annual Meeting		18,850.00
Interest Earned		1,442.71
Total		$458,501.39
OFFICIAL JOURNAL—*California Medicine:*		
Advertising	$ 87,129.51	
Members' Subscriptions Allocated from Dues	32,133.00	
Other Subscriptions	2,064.53	
Reprints (net)	485.75	
Total		121,812.79
TOTAL INCOME		$580,314.18

EXPENDITURES

Administration	$128,751.28	
Scientific, Educational and Public Relations	258,537.92	
Total	$387,289.20	
Official Journal—*California Medicine*	101,402.08	
Total		488,691.28
EXCESS OF INCOME OVER EXPENDITURES		$ 91,622.90
SURPLUS CREDITS:		
To reflect cash surrender value of life insurance policy	$ 2,211.60	
To reflect unrecovered lease deposit	274.00	
Unexpended public relations expenses at June 30, 1949	1,366.60	
To adjust prepaid rental account	183.16	
American Cancer Society salary contribution for Cancer Commission	220.00	
Reduction in reserve for New Mexico Physicians' Service loan	3,000.00	
Total		7,255.36
TOTAL		$ 98,878.26
SURPLUS CHARGES:		
Transfer of assets to Trustees of the California Medical Association:		
U. S. Treasury Bonds—at maturity value	$100,000.00	
Accrued interest	1,140.71	
Total	$101,140.71	
Absorption of bond premium paid on the above bonds	3,437.50	
Total	$104,578.21	
Expenses applicable to a prior period:		
Legal fees	$5,500.00	
Federal unemployment taxes	84.90	5,584.90
TOTAL		110,163.11
DECREASE IN SURPLUS FOR THE YEAR		$ 11,284.85
SURPLUS AT BEGINNING OF YEAR		408,912.07
SURPLUS AT END OF YEAR		$397,627.22

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, California

STATEMENT OF EXPENDITURES

For the Year Ended June 30, 1950

ADMINISTRATION:		
Salaries:		
Executive Secretary	$ 18,000.00	
Administrative	10,725.00	
Clerical	9,569.68	$ 38,294.68
Traveling:		
Executive Secretary and Secretary	$ 1,189.36	
Officers	1,385.23	
Council and Executive Committee	4,795.95	7,370.54
Annual Meeting Expenses—Including Transportation		21,885.44
American Medical Association Convention—Delegates' Traveling and Sundry Meeting Expenses		13,583.25
Council and Executive Committee Expense		2,708.15
County Secretaries' Conference		1,205.12
Los Angeles Office Expenses		2,028.42
Legal and Organization Expense:		
Legal:		
Retainer	$ 6,000.00	
Other	3,092.28	
Total	$ 9,092.28	
Organization Expense	8,770.25	17,862.53
Office Expenses:		
Office Rent	$ 5,630.28	
Telephone and Telegraph	2,258.40	
Supplies and Expense	4,057.30	
Postage	935.34	
Annuities	1,529.72	14,411.04
Other Expenses:		
Equipment Purchased	$ 1,393.40	
Pay Roll Taxes	1,114.71	
Pensions	4,620.00	
Contributions:		
The Woman's Auxiliary to the California Medical Association	750.00	
Ray Lyman Wilbur Memorial Fund	1,000.00	
Miscellaneous	524.00	9,402.11
SCIENTIFIC, EDUCATION AND PUBLIC RELATIONS:		
Department of Public Relations	$124,713.81	
Public Policy and Legislation	62,289.98	
Physicians' Benevolence	10,359.75	
Postgraduate Activities	10,459.99	
Cancer Commission	26,329.59	
Other Committee Activities	14,204.94	
Medical Economics	5,000.00	
Subscriptions to Libraries	5,179.86	258,537.92
OFFICIAL JOURNAL—*California Medicine:*		
Printing	$ 66,755.37	
Advertising Sales Expense	8,889.86	
Salaries	14,292.17	
Rent	1,956.00	
Telephone and Telegraph	801.29	
Postage and Mailing	3,979.84	
Addressograph	1,803.08	
Illustrations	1,210.61	
Advertising Discounts and Collection Expenses	1,487.73	
Sundry	226.13	101,402.08
TOTAL EXPENDITURES		$488,691.28

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino and San Diego Counties

To the President and the House of Delegates:

The custom of an annual visit to the county medical societies by the officers of the California Medical Association has been revived this year. Dr. Donald Cass and Messrs. Ben Read and Ed Clancy have included talks with the Woman's Auxiliaries of the various societies with these visits.

Your Councilor has had the opportunity to introduce them at these meetings during the autumn months in San Bernardino and Riverside counties. During the month of January it is our plan to include Riverside, San Diego and Imperial county societies with similar visits. We hope that the revival of these annual meetings will not be short-lived, although it does seem that World War III may very well result in a resumption of wartime restrictions on travel.

It continues to be difficult to keep up with the rapid growth of California Medical Association, which is now the second largest state medical association in the United States. It is gratifying to note that the National Educational Campaign of the American Medical Association is merely an enlargement of the program so successfully developed by the California Medical Association under the direction of Whittaker and Baxter. The results of the November elections speak conclusively of the effectiveness of the program thus developed. It must be remembered, however, that "We have just begun to fight."

The problems of public relations are still being studied and we continue to make every effort to promote good public relations and are ever alert in our effort to prevent poor public relations.

I have regularly attended all of the meetings of the Council this year; the minutes of these meetings have already been duly published in CALIFORNIA MEDICINE.

I feel certain that the medical profession will again meet the challenge of the call to arms. The increased burden for those, both in the services and out, will be borne with the same patriotism and awareness of responsibility as previously. The Council will continue to function effectively under the able chairmanship of Dr. Sidney J. Shipman in spite of the additional problems bound to develop as the war effort continues to grow.

Respectfully submitted,

JOHN D. BALL, *Councilor,*
First District

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

The resolutions to be presented to the House of Delegates of the California Medical Association this year will be very interesting and important. Every year the business transacted by the House of Delegates grows, more committees are necessary, and the profession at large is more active and interested in what is going on. It is necessary that all members of the California Medical Association, not just a few, become acquainted with the work of the House of Delegates and the activities of the Association. Those who are interested should appear before the different committees of the House of Delegates and discuss the various resolutions. All should attend the meetings of the House of Delegates, especially delegates, alternates, and county association and hospital staff officers.

In short, I urge that more attention be paid to the resolutions and business of the Association and House of Delegates by the doctors of California and for them to present resolutions through their own delegates for the House's consideration.

During the year of 1950 your delegate from District Two attended all of the Council's meetings. In our Journal the Council's transactions have been printed and I hope read by all.

Respectfully submitted,

JAY J. CRANE, *Councilor,*
Second District

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, Ventura and Inyo-Mono Counties

To the President and the House of Delegates:

All the societies of the Third Councilor District have increased their memberships and are very active.

The blood bank which was sponsored by the three coastal counties for this area is functioning very well and has been one of the major projects of the District for the past year.

Respectfully submitted,

H. E. HENDERSON, *Councilor,*
Third District

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mariposa, Calaveras, San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

This is my first year as a Councilor, representing the Fourth District, and as such I have not been able to contribute much to the activities of the California Medical Association. I have attended all the Council meetings and have visited with the societies in the area. Perhaps our best meetings were those where Dr. Donald Cass, Dr. Gordon MacLean and Mr. John Hunton were able to attend. These grass-roots meetings were well attended and well received.

During the past year, not as an activity of the California Medical Association but as an activity of a group of doctors, dentists, and pharmacists, a non-partisan public health league was formed for the procurement of better government. This league was quite active in the last election and they expect to remain as an organization for future work that may be necessary.

In Fresno County our executive secretary, Mr. Glenn Gillette, has done a very good job in directing the activities of the different committees and in public relations work for our society.

Respectfully submitted,

NEIL J. DAU, *Councilor,*
Fourth District

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties

To the President and the House of Delegates:

The Fifth Councilor District has had a very successful year. Monterey County has increased its membership from 102 to 115 members. The society has rewritten its constitution and adopted it and is preparing to incorporate the society. Ground has been broken for the Salinas Valley Memorial Hospital. This new hospital will be a five-story, 139-bed hospital of the latest design. This is a district hospital and is expected to be completed in eighteen months. The civil defense committee of the medical society is busy organizing a "walking blood bank," whereby as many persons as can will be typed and given dog-tags showing type and Rh. This committee is ably headed by Dr. S. C. Rascoe and assisted on the laboratory side by Dr. Ernest Seard.

Santa Cruz County has had some increase in membership and has had good turnouts at all its monthly meetings. The members of this society are continuing their support of one of their confreres incapacitated by polio. The medical men of Santa Cruz County are contributing $100 each to this fund and are being helped some from the funds of the C.M.A.

San Benito County has had an increase of one member during the year. The woman's auxiliary has sponsored and formed a hospital auxiliary and has raised funds to build a new unit on the Hazel Hawkins Hospital in Hollister. This will increase the capacity of the hospital to a total of 26 beds. The blood bank program in San Benito County has been one of the most outstanding in the state. At the present time they are 400 per cent over their quota.

Santa Clara County has experienced a very rapid increase in new members for the county medical society. The society has expanded its advertising campaign initiated last year and has broadened its entire public relations program. There was a very satisfactory response to a series of advertisements guaranteeing medical care for all people who needed it in Santa Clara County regardless of ability to pay. This program was such a success that Mr. Joe Donnelly, executive secretary, was awarded one of the national prizes for constructive advertising.

San Mateo County has steadily increased its membership during the year. The society has expanded its organization and committee work to handle a large increase in medical problems. Several successful social events have gotten the medical profession of the county much better acquainted. Mr. Robert Wood, the medical secretary, has been highly instrumental in putting into effect a public relations program and has carried the work of the society, and to some extent of C.P.S., to the attention of the public. The plans for a new district hospital at Millbrae are completed and ready to go. The Sequoia High School District at Redwood City has built and dedicated its new hospital, which is now serving that community.

Respectfully submitted,

HARTZELL H. RAY, *Councilor,*
Fifth District

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

Under the leadership of William L. Bender the society which I represent has completed a full and fruitful year.

A complete revision of the constitution and by-laws was made and passed by the membership. Hereafter the organization will be known as the San Francisco Medical Society, the term "county" having been dropped. Among other changes, the new constitution sets up a president-elect, an assistant secretary-treasurer and separates the duties of editor of the bulletin from those of secretary-treasurer.

In order to stimulate increased interest in attendance at the society's general meetings the program committee under Chairman Edgar J. Munter inaugurated dinner meetings which were addressed by such outstanding medical leaders as Frank Lahey, Albert Snell, Paul O'Leary, Eduardo Braun-Menendez and Walter Alvarez. These meetings were very effective. As many as five hundred members were drawn to at least three of the meetings.

The admissions committee passed upon 154 applicants for membership of which 57 were for junior classification. The orientation lectures continue to be effective. Under the new constitution this committee is combined with the membership committee and enlarged to six. It is believed the result will be a more effective organization.

The increased defense activity has increased the importance of our blood bank commission and our representation on the mayor's civilian defense committee.

Several committees concerned themselves effectively with strictly medical problems such as cancer, diabetes control, health-education, problems of the deaf, industrial and mental health and the evaluation of hospitals and dispensaries.

Special attention was directed toward interesting the resident or junior physicians in the problems of medicine and demonstrating to them the services that are being rendered physicians by local, state and national organizations.

Many of the other activities cannot be enumerated for lack of space. 1950 was an effective year. 1951 promises to be a challenging one. Our society is well equipped in facilities, traditions and officer personnel to meet it.

Respectfully submitted,

M. LAURENCE MONTGOMERY, *Councilor,*
Sixth District

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

The outstanding development of the past year has been the amalgamation of the Alameda County and Contra Costa County medical associations to form the Alameda-Contra Costa Medical Association. Several services of the Alameda County Medical Association were widely used in Contra Costa County, especially the Bureau of Medical Economics and the malpractice insurance plan. The unification of the two societies allows further utilization of all services and permits more efficient administration of such services.

The association has gathered information and kept its members informed as regards assignment and procurement and problems pertinent to military service. An advisory committee to assignment and procurement service was set up and has been of particular value in its cooperation with the military authorities.

The Alameda County-Contra Costa County Medical Plan continues in its development towards maturity. There are still many growing pains as it passes through adolescence.

Respectfully submitted,

DONALD D. LUM, *Councilor,*
Seventh District

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties

To the President and the House of Delegates:

The visits of Dr. MacLean and Mr. Hunton to each of the societies comprising the Eighth District during the last year were well received and helped to further understanding and good will between the county and state societies. Two new Woman's Auxiliaries have been organized in this area during the last year. Reasonable progress is being made in the addition of hospital beds which remain inadequate in several areas. A number of the younger men are again being inducted into the armed services. The provisions of the present draft law relating to Doctors have the overwhelming support of the profession, and the medical advisory boards which have been set up to assist the draft boards appear to be functioning satisfactorily.

Blood banking facilities under medical supervision have continued to expand, and when present plans for a bank at Redding have materialized, adequate coverage for Northern California will have been obtained.

Respectfully submitted,

WAYNE POLLOCK, *Councilor,*
Eighth District

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

Due to illness, which began on November 7, 1950 (having no records at home), and being continuously confined to the house ever since, this report is necessarily brief.

There have been no problems in this District during the period covered by this report. President-Elect H. Gordon MacLean made his visit to the county societies during the summer and fall, in company with Executive Secretary John Hunton. These visits were of distinct value to the membership as well as to members of the Woman's Auxiliary. We feel this practice should be continued when it is possible to do so. Irwin Memorial Blood Bank, in conjunction with the local chapters of the American Red Cross, has been busy with the collection of whole blood in the counties around the Bay. The Mare Island Naval Hospital has been reactivated, after having been closed since June, and now has over 800 patients, mostly Korean casualties.

Respectfully submitted,

JOHN W. GREEN, *Councilor, Ninth District*

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

As one of your Councilors-at-Large, I have regularly attended the meetings of the Council and Executive Committee during the past year. Inasmuch as the minutes of these meetings have been duly published in CALIFORNIA MEDICINE, it is unnecessary to comment on them further. Suffice it to say it is my impression that the Council, as now constituted, has functioned effectively in dealing with the many problems which have arisen during the year.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Councilor-at-Large*

To the President and the House of Delegates:

As Councilor-at-Large I have attended the meetings of the Council of the California Medical Association and have taken part in the discussions and decisions of the Council. I have also carried out committee and other assignments.

In addition, as director of the San Francisco County Medical Society, I have endeavored to correlate state and county organizations.

Respectfully submitted,

IVAN C. HERON, *Councilor-at-Large*

To the President and the House of Delegates:

The legislative committee of the Council and the legislative committee of the Board of Medical Examiners have worked closely together preparing legislative bills in the interest of the public health and welfare. Among these bills are some which propose that the practice of medicine without a license (like the practice of dentistry without a license) should be made a *grand* misdemeanor for the first offense, and a felony for the second offense, instead of an *ordinary* misdemeanor as is the case at the present time. Several other similar bills to prevent blood pressure readings made by street-corner operators, and other forms of quackery, have been introduced.

In collaboration with the deans of the various medical schools, the requirements for medical training were revised and simplified in the light of modern advancements, with such obsolete subjects as materia medica being eliminated. The entire approach to the subject of examinations was revised with emphasis being placed on the approval of medical schools rather than on the precise number of hours of education to which the candidate had been exposed.

It was also proposed that if a doctor of medicine was adjudged as insane, he should not be deemed guilty of "unprofessional conduct," as is the case at the present time, but should instead have his license suspended until evidence of restoration or declaration of sanity was shown.

Respectfully submitted,

WILBUR BAILEY, *Councilor-at-Large*
President, State Board of Medical Examiners

To the President and the House of Delegates:

The past year has added war preparation, disaster relief and other new matters of great import to the usual routine work of the Council in administering your Association's business. Study, discussion and then decisions have been rendered to the best of their ability. The results have been most gratifying.

Respectfully submitted,

BEN FREES, *Councilor-at-Large*

To the President and the House of Delegates:

During the past year I have attended the Council meetings, and meetings of several committees. I have also been privileged to attend several meetings of the State Advisory Hospital Council. As a Councilor I have participated briefly in the meetings of my own county association.

The published reports and proceedings of the meetings bear witness to the serious thought given to the affairs of the Association by all of your elected officers—and employees.

Respectfully submitted,

C. V. THOMPSON, *Councilor-at-Large*

REPORTS OF COMMITTEES

EXECUTIVE COMMITTEE

To the President and the House of Delegates:

The Executive Committee has held meetings between Council meetings and such special meetings as were necessary to act upon matters which needed prompt attention. The minutes of the Executive Committee have been presented to the Council for approval and have been subsequently published in CALIFORNIA MEDICINE.

All members of the Executive Committee have been most attentive and cooperative in their work.

Respectfully submitted,

DONALD D. LUM, *Chairman*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

To the President and House of Delegates:

Resolution 19, adopted by the House of Delegates in session May 2, 1950, was referred by the Council to this Committee for study and recommendation. This resolution calls upon the California Medical Association and the component county societies to (1) set up required standards of education and an appropriate code of ethics for psychologists who work under the direction of the medical profession, and (2) make available for the use of the medical profession and the public a list of such recognized psychologists.

A meeting of the full Committee was held in San Francisco June 27, 1950, with Thomas D. Cutsforth, psychologist from Los Angeles, present by invitation.

It was the opinion of the Committee that it is entirely impracticable, at the present time, for the medical profession to attempt to establish required standards of education for psychologists.

The code of ethics proposed by the clinical psychologists who are members of the American Psychologic Association and are engaged in psychotherapy and private practice in the Los Angeles area was carefully reviewed. Objection was made to Item 1 and Item 2 on the grounds that these implied that primary clinical responsibility is vested in the psychologist. He decides whether or not to refer patients to an M.D. for physical complaints, and to whom to refer patients. It was the unanimous opinion of this Committee, and agreed to by Mr. Cutsforth, that this should be changed to guarantee acceptance of patients only from an M.D. for specific treatment. Such change would conform to the opinion of this Committee that primary clinical responsibility should, at all times, belong to a doctor of medicine.

The Committee made the following recommendations in regard to a registry of psychologists:

(1) That the psychologists themselves, through the American Psychological Association or the committee on professional ethics of the clinical psychologists in private practice in the Los Angeles area, prepare a registry list of those psychologists whom they consider properly qualified and who subscribe to their code of ethics as modified by previous suggestion of this Committee.

(2) That this registry list, underwritten by the American Psychological Association and not by the California Medical Association, be made available in any county medical society office to be used exclusively as a source of information for the members of the local county medical society. Under no circumstances should this registry list be made available to the lay public.

(3) That this registry list be subject to critical review and correction yearly.

The Council approved the report of the Committee at its meeting September 9, 1950.

The Council also referred to this Committee for recommendation a request from the Alameda County Medical Association for assistance in making effective the requirements of the American College of Surgeons for hospital approval without the necessity of frequent staff meetings requiring compulsory attendance.

The Committee is unable at this time to offer any constructive suggestions for such assistance. It does recommend that a serious study of this important problem be carried out in the coming year by the appropriate committee.

Respectfully submitted,

ROBERT A. SCARBOROUGH, *Chairman*

AUDITING COMMITTEE

To the President and the House of Delegates:

A survey of business procedures of the California Medical Association was made by a certified public accounting firm. Recommendations were made as to changes in minor procedures which were approved by the Council and placed in effect. All records were found to be in good order.

The Committee has also made recommendations to the Council concerning the 1951 budget.

Respectfully submitted,

DONALD D. LUM, *Chairman*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

To the President and the House of Delegates:

The Committee on Health and Public Instruction has attempted to keep in touch with health activities concerning practicing physicians, public health officials, and the general public. While no formal meetings have been held during the past year, the Committee stands ready at all times to assist the Association in the field of health education.

Respectfully submitted,

ORRIN S. COOK, *Chairman*

COMMITTEE ON HISTORY AND OBITUARIES

To the President and the House of Delegates:

The Committee on History reports that the search for source material needed for a history of the State Medical Association continues. The records of the early years of organized medicine in California are meager and hard to find. Medical and lay press alike give only scant information on medical organization of 100 years ago. Much accessory reading is necessary to glean occasional items of factual and historical worth.

Recently a letter was sent to the county societies asking them to forward their early minute books to the California Medical Association Historian, Dr. George H. Kress of Los Angeles, who aimed to use the same in working out a skeleton sketch of each county society's beginnings and past. The C.M.A. Committee on History hopes the county medical societies will lend their cooperation in this endeavor.

The Committee is happy to report the publication during the past year of "Memories, Men and Medicine" by J. Roy Jones, M.D., of Sacramento. This volume, representing years of research, is a history of medicine and medical men of Northern California and particularly of Sacramento and Sacramento County from 1849 to 1949. This valuable work was sponsored by the members of the Sacramento Society for Medical Improvement, and it is to be hoped that the success of their efforts will stimulate other medical groups to publish the history of medicine in their own districts. Dr. Jones is engaged at present in the preparation of "Saddlebags in Siskiyou," a history of the medical pioneers of his native county.

Obituaries: The records of the California Medical Association as of January 10, 1951, show that during the past year death has claimed 109 California doctors. Your Committee recognizes that this number falls short of the actual total. In our report for 1949 we recorded 105 deaths, the total known at the time the report was written. Subsequent to the filing of the report the C.M.A. received notice of the passing in 1949 of 29 additional California doctors. The names, together with records of age, date and place of graduation, society membership, cause of death and other data of the 109 doctors whose deaths are here reported, have all appeared in the files of CALIFORNIA MEDICINE. The list contains the names of many men of state and national reputation. Most of them were known personally to the members of your Committee, and in many cases their passing has meant the termination of years of friendship. Paraphrasing the words of Paul to Timothy, "They have fought a good fight, they have finished their course, they have kept the faith." To our departed confreres—Hail and Farewell.

Respectfully submitted,

ROBERT A. PEERS

COMMITTEE ON HOSPITALS, DISPENSARIES, AND CLINICS

To the President and the House of Delegates:

The Committee on Hospitals, Dispensaries and Clinics has had no meetings since the last Annual Meeting of the California Medical Association. Since I have been chairman of the committee, no communication or business has been referred to the committee for action.

Respectfully submitted,

JOHN B. HAMILTON, M.D., *Chairman*

COMMITTEE ON INDUSTRIAL PRACTICE

To the President and the House of Delegates:

During the year 1950 no problems have been referred to the Committee on Industrial Practice by the Council or the House of Delegates. No meetings of the Committee were held during the year, no business was transacted and there is no unfinished business.

Respectfully submitted,

R. M. WALLERIUS, *Chairman*

COMMITTEE ON MEDICAL DEFENSE

To the President and the House of Delegates:

The Committee on Medical Defense has had no meetings during the past year, and no communication or business has been referred to the committee for action.

Respectfully submitted,

H. CLIFFORD LOOS, *Chairman*

COMMITTEE ON MEDICAL ECONOMICS

To the President and the House of Delegates:

The Committee on Medical Economics studied two subjects during the past year:

(1) The individual doctor-patient relationship,

(2) Physician abuses of insurance companies.

With the aid of a business psychologist and Mr. Rollen Waterson, executive secretary of the Alameda-Contra Costa Medical Association, the study of the individual doctor-patient relationship has been completed. A full report will be presented to the Council of the C.M.A. before the 1951 Annual Session.

The study of the physician abuses of insurance companies is now going on, in cooperation with insurance groups. Much information is expected to be obtained. This report also will be given to the Council before the 1951 Annual Session.

Respectfully submitted,

H. GORDON MACLEAN, *Chairman*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

To the President and the House of Delegates:

The Committee has had no meetings and no business has been referred to it by the officers or Council.

The problems of financing the five medical schools and the teaching hospitals in California should be considered by the Association.

Respectfully submitted,

LOREN R. CHANDLER, *Chairman*

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

To the President and the House of Delegates:

Membership in the California Medical Association shows a growth in 1950 commensurate with the increase of medical licentiates in the state during the same period. Los Angeles County still leads with 4,535 members, as contrasted with 6,920 licentiates in the same area. The California Medical Association has now become the second largest state association in the nation.

The wisdom of increasing state association membership with special drives or by other means has been previously discussed. It seems to be the consensus of opinion that the natural growth of this our organization is consistent with the growth of organized medicine throughout the nation. Several small population areas in the state show little or no growth during the past few years, but these could be anticipated by the static condition of medical and general population.

Herewith is appended a resume of membership by counties given out by the executive office of the California Medical Association.

Respectfully submitted,

CARL L. MULFINGER, *Chairman*

C.M.A. County Society Membership Totals For Calendar Year 1950

County Medical Societies	Membership in 1949	Number Licensed Physicians (1949 Directory)	Membership in 1950	Number Licensed Physicians (1950 Directory)
Alameda-Contra Costa	894	1,408	957	1,485
Butte-Glenn	52	67	60	76
Fresno	206	232	217	254
Humboldt	41	60	54	59
Imperial	31	39	36	45
Inyo-Mono	11	15	8	17
Kern	116	182	126	205
Kings	24	30	22	29
Lassen-Plumas-Modoc	18	27	21	31
Los Angeles	4,261	6,672	4,535	6,920
Marin	71	115	74	127
Mendocino-Lake	28	44	23	53
Merced-Mariposa	39	62	36	47
Monterey	105	142	111	158
Napa	44	76	47	79
Orange	202	278	207	292
Placer-Nevada-Sierra	47	74	49	72
Riverside	110	173	113	180
Sacramento	238	292	249	295
San Benito	7	9	7	11
San Bernardino	227	306	238	320
San Diego	473	731	492	780
San Francisco	1,319	2,179	1,376	2,240
San Joaquin	142	194	140	177
San Luis Obispo	41	55	45	56
San Mateo	173	273	210	302
Santa Barbara	137	177	147	187
Santa Clara	303	431	323	479
Santa Cruz	60	83	63	90
Shasta-Trinity	20	34	22	36
Siskiyou	15	19	15	22
Solano	60	103	60	106
Sonoma	95	115	99	128
Stanislaus	69	99	85	106
Tehama	9	13	11	13
Tulare	72	88	78	98
Ventura	62	110	66	115
Yolo	26	30	31	31
Yuba-Sutter-Colusa	37	43	39	47
Totals	9,885	15,080	10,492	15,768

COMMITTEE ON POSTGRADUATE ACTIVITIES

To the President and the House of Delegates:

During the year of 1950, this Committee has met once every two months with a full attendance to plan the program and activities for the counties and the regions which do not have an active local postgraduate program.

Your Committee wishes to thank the Council of the C.M.A. for its active cooperation in its plans and for providing adequate funds, clerical help and office space to carry out the various projects.

Outside of the various metropolitan areas, many of the county societies are small and unable to provide, for themselves, an adequate program on the newer procedures in medicine and surgery. Your Committee has divided the state into five regions as follows: North Coast counties, West Coast counties, Sacramento Valley counties, San Joaquin Valley counties, and Southern counties. Each of these regional programs to be arranged by the postgraduate department of one of the five medical schools in the State of California respectively.

In accordance with this, institutes or conventions with lectures and demonstrations have been held for two days in Santa Barbara in October, in Fresno in November, in Riverside in January, in Sacramento in February, and in Santa Rosa in March.

In addition the Committee has furnished programs of shorter length for Redding, Marysville, and Bakersfield. Others are planned for several of the county societies during the spring of 1951.

To direct this work, Dr. C. A. Broaddus of Stockton was appointed as Director of Postgraduate Activities in February 1950, and provided with a secretary and a local office in Stockton.

For the year 1951-52 a second series of meetings is planned for the five regional areas. Each program will be planned by a local committee in conference with the head of the postgraduate department of one of the five medical schools and the director of postgraduate activities of C.M.A. The Committee is certain in view of attendance, that these conventions will become larger, and with better programs will interest many other groups in their attendance.

A statewide advisory committee met in San Diego in the spring of 1950, consisting in addition to your Committee of the following: Drs. Arnot, Brock, Chamberlain, Dozier, Halverson, Kinney, Molony, Sr., McClendon, Mettier, Northway, Rosenow, Thienes, Walton, and Weinberg. Many valuable suggestions were received and your Committee recommends that more of these meetings be held from time to time.

In addition to the regional conventions, your Committee is available to help local county societies in any manner in their efforts to put on local postgraduate programs for their members. Your Committee intends to cooperate with the various medical societies and commissions and assist them in making contacts with local groups.

Your Committee requests the House of Delegates that the Council of the C.M.A. be directed to continue the allocation of funds for the support of this committee in making possible postgraduate opportunities for its members.

Your Committee feels elated over the enthusiastic reception of their program of postgraduate refreshment by the members of the California Medical Association. Your Committee feels that the pattern of postgraduate activities in this state is one that could well be copied by all other states. These meetings have been accepted by the Academy of General Practice, and certified attendance at them enables the general practitioner to fulfill his postgraduate requirements as specified by the Academy of General Practice.

The C.M.A. is to be congratulated in fulfilling its mission to its membership in making postgraduate opportunities available to them.

Respectfully submitted,

JOHN C. RUDDOCK, M.D., *Chairman*

COMMITTEE ON PUBLICATIONS

To the President and the House of Delegates:

CALIFORNIA MEDICINE continues to improve. It holds a high place among medical publications. Its subject matter is well selected. Its advertisements are well displayed. In these rapidly changing times, it keeps pace with our changing conditions. Your committee feels that the only major changes to be made in our publication will be those that of necessity must be made in stride with mobilization for defense.

Respectfully submitted,

GEORGE I. DAWSON, *Chairman*

COMMITTEE ON SCIENTIFIC WORK

To the President and the House of Delegates:

The Committee on Scientific Work held two meetings during the year and two meetings with the section officers.

The 1951 Scientific Program will be changed somewhat from that of previous meetings. Two afternoons have been kept free to allow the House of Delegates to meet at an earlier hour. Each section has been limited to two sessions exclusive of joint sessions.

At the request of this Committee the Chairman of the Council reactivated the Committee on Local Arrangements. It was felt that this latter committee could render valuable help as the Los Angeles meeting may be quite large.

The policy of not sanctioning the meetings of other medical organizations during the three and one-half days required for the State Meeting has been maintained.

The C.M.A. Press Officer, Mr. Robert Edwards, will again be in charge of the press coverage. His excellent work last year in San Diego should be commended.

There will be a "Meet the Press" luncheon on Saturday, May 12, as was held last year.

Section aides, renamed section executives, have been appointed by each section to be present at section meetings and to facilitate in every way possible their respective programs. It is upon the satisfactory functioning of these section executives that the smoothness of section meetings will depend.

Respectfully submitted,

ALBERT C. DANIELS, *Chairman*

REPORT OF EDITORIAL BOARD CALIFORNIA MEDICINE

To the President and the House of Delegates:

There was no change in the membership of the Editorial Board during the past year. No formal meetings of the Executive Committee of the Board were held.

The members of the Editorial Board are:

Chairman of the Board:
Dwight L. Wilbur, San Francisco

Executive Committee:
Albert J. Scholl, Los Angeles
H. J. Templeton, Oakland
Edgar Wayburn, San Francisco
Dwight L. Wilbur, San Francisco

Allergy:
Frank J. Crandall, Jr., Los Angeles
Samuel H. Hurwitz, San Francisco

Anesthesiology:
William B. Neff, San Francisco
Charles McCusky, Los Angeles

Dermatology and Syphilology:
Paul Foster, Los Angeles
H. J. Templeton, Oakland

Ear, Nose and Throat:
Lawrence K. Gundrum, Los Angeles
Lewis Morrison, San Francisco

Eye:
Frederick C. Cordes, San Francisco
A. R. Robbins, Los Angeles

General Medicine:
Maurice Sokolow, San Francisco
O. C. Railsback, Woodland
Edgar Wayburn, San Francisco
John Martin Askey, Los Angeles
W. E. Macpherson, Los Angeles

General Surgery:
Frederick L. Reichert, San Francisco
C. J. Baumgartner, Beverly Hills

Orthopedic Surgery:
Frederick C. Bost, San Francisco
Hugh Jones, Los Angeles

Thoracic Surgery:
John C. Jones, Los Angeles
H. Brodie Stephens, San Francisco

Industrial Medicine and Surgery:
Rutherford T. Johnstone, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
George W. Pierce, San Francisco
William S. Kiskadden, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, Los Angeles
Donald G. Tollefson, Los Angeles

Pediatrics:
E. Earl Moody, Los Angeles
William G. Deamer, San Francisco

Pathology and Bacteriology:
Alvin G. Foord, Pasadena
Alvin J. Cox, San Francisco

Psychiatry and Neurology:
Karl M. Bowman, San Francisco
John B. Doyle, Los Angeles

Radiology:
R. R. Newell, San Francisco
John W. Crossan, Los Angeles

Urology:
Lyle Craig, Pasadena
Albert J. Scholl, Los Angeles

Pharmacology:
Hamilton H. Anderson, San Francisco
Clinton H. Thienes, Los Angeles

Public Health:
George Uhl, Los Angeles
Charles E. Smith, San Francisco

Respectfully submitted,

DWIGHT L. WILBUR, *Chairman*

PHYSICIANS' BENEVOLENCE COMMITTEE

To the President and the House of Delegates:

The Benevolence Committee has continued its previous policies in the past year, contributing regularly to the work of the Los Angeles County Physicians' Aid Association and taking care of needy physicians and their families in other counties. A complete financial report is shown herewith and is self-explanatory:

BENEVOLENCE FUND
RECEIPTS AND EXPENDITURES
January 1950 Through December 1950

January 1, 1950, Balance:		
Cash		$10,377.89
U. S. Treasury Bonds		22,000.00
		$32,377.89
Receipts:		
Interest on Savings Account	$ 20.82	
Interest on U. S. Bonds	440.00	
Contribution—Woman's Auxiliary	3,555.16	
Contribution—C.M.A.	10,318.00	14,333.98
		$46,711.87
Expenditures:		
Premium on U. S. bonds purchased	$ 42.00	
Benefits paid	8,464.84	8,506.84
December 31, 1950, Balance		$38,205.03
Cash	$11,205.03	
U. S. Treasury Bonds	27,000.00	
	$38,205.03	

The Committee wishes to call attention to the fact that its investment account in U. S. Treasury Bonds returned $440 in interest income last year and will show an even better return for 1951. Interest funds are reinvested as they are received.

The Committee wishes to thank all those who have cooperated so well in its activities in the past year, especially those physicians and members of the Woman's Auxiliary who have taken the time and trouble to bring needy cases to its attention and to aid in the proper disbursement of funds. Within the past year two polio cases have been given assistance and other cases of need have been assisted. One recipient of aid died within the year and the Committee contributed to a proper burial.

The chairman wishes especially to express his thanks to Doctors Elizabeth Mason-Hohl and John W. Sherrick, committee members, for their prompt and unfailing response to all calls for assistance. Their decisions have been immediately forthcoming in all instances, and without their good work the results of the committee would be less satisfactory.

Full credit goes to the Woman's Auxiliary to the California Medical Association, which last year contributed $3,555.16 to the Benevolence Fund. The Auxiliary has increased its annual contribution in each of the past few years and the 1950 sum is a new high. This generous response by the Auxiliary has made it possible to carry on the work of the Committee and to add to the permanent endowment fund which is accumulating from year to year.

In view of the increased costs of necessary items of relief and considering that we now have a backlog of funds which would enable us to do so, it is thought by your Committee that an increase of allowances should be made to those who require help, and, unless otherwise directed, your Committee will make more generous allowances in the future.

The Los Angeles County Physicians' Aid Association has just opened and dedicated a home for the care of the needy who require home or institutional care. Your Committee will later submit to the Council of the C.M.A. a statement of conditions and expenses involved in securing care at the Los Angeles home for possible cases outside of that area and, if approved, will make arrangements with the Los Angeles Physicians' Aid Association for such services.

Respectfully submitted,

AXCEL E. ANDERSON, *Chairman*

COMMITTEE ON PUBLIC RELATIONS

To the President and the House of Delegates:

The Committee on Public Relations has stood by during the past year, ready to serve under direction of the Council. The actual public relations activities of the Association have been under the supervision of the Council, through outside public relations counsel and through the Advisory Planning Committee and the Committee on Medical Economics, both of which have devoted their efforts to working on specific phases of the over-all plan of public relations. Accordingly, this Committee has been inactive. The Committee is composed of the chairmen of the standing committees of the Association, with the executive secretary named as director of public relations.

Respectfully submitted,

JOHN HUNTON, *Director*

ADVISORY PLANNING COMMITTEE

To the President and the House of Delegates:

The Advisory Planning Committee has met on the day preceding each Council meeting, has discussed various matters for recommendation to the Council for consideration and has previewed the items to come before the Council on the following day. The recommendations of the committee have appeared in the published reports of the Council.

Most important item originating with the committee in the past year has been a program of public relations at the level of the county medical society and its individual members. A statement of the objectives of such a program has been submitted to the Council, together with a recommendation for activation of progressive portions of the entire program. Additional reports on this subject are to be made by the committee and the activation of further portions of the program will be recommended when such procedure is indicated.

Respectfully submitted,

JOHN HUNTON, *Chairman*

C.M.A. BLOOD BANK COMMISSION

Annual Report 1950

To the President and the House of Delegates:

Events of the past year have focused an unusual amount of public attention upon the work of our blood banks; this interest was due in part to the Korean war and to the successful participation by the numerous C.M.A.-sponsored blood banks in the Armed Forces blood program. However, your Commission members realize that the accelerated program, dramatic as it was, and is, was made possible by careful planning through the years 1946 to 1950.

Our state is still not completely covered by blood bank facilities, but it is better organized than at any time in the past. Each new community blood bank brought into operation during the last three years is now worth more than a regiment of infantry. *Blood is more valuable than bullets.*

Accomplishments: 1. Sponsored and actively aided in the creation of the following three blood banks: (a) Tri-Counties Blood Bank. This bank is situated in Santa Barbara and completely serves San Luis Obispo, Santa Barbara, and Ventura counties. (b) Northern California Community Blood Bank is situated in Eureka. This bank serves Humboldt and Del Norte counties. (c) San Diego Blood Bank. This bank opened December 1, 1950, and will service San Diego and part of the Imperial Valley.

2. Organization stage: (a) San Bernardino-Riverside-Redlands regional bank. The bank will be situated in San Bernardino. (b) Kern County Blood Bank will be located in Bakersfield and will serve the lower part of the San Joaquin Valley.

3. Suggested bank: (a) Redding-Red Bluff area. This northern zone has the population, the technical medical know-how, and sufficient active hospital beds to support a blood bank. Creation of such a vital institution should be the chief concern of the respective medical societies in 1951.

Red Cross: A reciprocity agreement was signed with the American National Red Cross on September 29, 1950. The agreement states: (a) Inter-blood-bank exchanges will be settled on a unit-for-unit basis. (b) There will be an exchange of funds, wherever necessary to balance accounts, for the actual per unit cost of processing blood. (c) Territorial boundaries to be served by each of the banks operating under the two systems will be defined, thus allowing for expansion. Plans for expansion are subject to the approval of the local county medical society. (d) American Red Cross volunteers may be provided at the request of any of the participating blood banks. (e) The agreement may be terminated by either party on a 60-day written notice.

If the intent of this agreement is faithfully carried out, it will provide better service to the people of the state and redound to the credit of both the Red Cross and medicine.

Armed Forces Blood Program: The system of C.M.A.-sponsored blood banks was the first integrated system to offer its widely dispersed facilities to the U. S. Government when the Korean war started. This offer of assistance was made by telegram July 11, 1950, to Dr. Richard Meiling, director of the combined medical services. Seven of our blood banks have played a dominant role in the "Blood for Korea" program. Practically all of the whole blood flown to Korea was drawn on the Pacific slope. The San Diego Blood Bank was prevented from participating in the program due to a most unfortunate set of circumstances, circumstances which should never have been allowed to occur. The director of that bank and some of his committee deserve special commendation for their forthright stand against injustice and unpatriotism. They will be amply vindicated in the future, for their course was right, honest, and taken on behalf of their medical responsibility to their city, their county, and their state.

The Red Cross assigned the C.M.A.-sponsored blood banks a December quota of 10,000 units; 9,452 units were distributed. Some of the banks went over their quotas, and a couple did not, primarily because they did not enter the program the first part of December and because Red Cross donor recruitment varies in each locale. The above blood production was over and above the blood banks' civilian service.

Licensure: Instituted the necessary procedure for obtaining biologics licensure from the National Institute of Health for our state banks that were not already under this department's jurisdiction. This license was necessary before any bank can participate in the Armed Forces program. The National American Red Cross is the agent that decides which bank will draw blood. This procedure should be liberalized immediately as it is capable of misuse and has already prevented one of our banks from participating in the program which is of vital importance during the present emergency. Organized medicine should have a voice in decisions on the granting of licenses so that an impartial technical and administrative analysis can be made on all blood banks. All banks operating under our system more than meet the minimum requirements of the N.I.H.

Financial Loans: A non-interest-bearing loan was made by the C.M.A. to the San Diego Medical Society for the creation of a community blood bank, and money was offered to certain banks for the purchase of emergency supplies, i.e., for civilian disaster preparedness.

Brochure: A booklet was published, entitled "California's Life Line." This brochure received an enthusiastic reception, and many requests for it were received from the nation and from foreign countries. A second edition is being readied and brought up to date to meet the continuing demand.

Meetings: The American Association of Blood Banks met in Chicago; it was attended by the chairman of your Blood Bank Commission. Technical and administrative problems were widely discussed and a great deal of pertinent work accomplished. Our exhibit was a highlight of the meeting and received considerable attention.

Many trips were undertaken throughout the state. Eureka, Santa Rosa, Sacramento, San Diego, and Santa Barbara were a few of the banks visited. The spirit of cooperation between these institutions is noteworthy and most stimulating.

Exhibits: Our blood bank system exhibit was shown during the C.M.A. meeting in San Diego and at the A.M.A. convention in San Francisco. Bakersfield, Santa Rosa and San Diego also used the exhibit. It was this same presentation which was shown in Chicago during the American Association of Blood Banks meeting.

Clearing House: A central office for our state system of non-profit blood banks was created and is located at 2180 Washington Street, San Francisco, telephone JOrdan 7-6400. This central agency will greatly expedite the ever-increasing amount of administrative business. The potentialities for this agency are tremendous. Coordination, integration, statistics, research, inter-blood-bank exchange of blood and funds, etc., are but a few of the immediate pressing developments which must be expanded.

It is impossible for me to express adequately my gratitude and sincere thanks to the Executive Council of the C.M.A. They have supported me on all controversial issues and they have been a tower of strength when downright force was required. Without their support the "California Life Line" would not be a reality. That "Life Line" was able to stretch to Korea and provide blood to our wounded. The banks constituting the "Life Line" *were ready.* Nothing must sever or try to discredit that "Life Line"; it plays too important a role in California's medical preparedness program to allow it to be sabotaged. Constant vigilance is the watchword.

To the members of the Blood Bank Commission go my admiration and thanks for their many hours of labor. Their timely advice and assistance greatly lightened my work. Their only reward has been to see the steady, healthy growth of our program.

The medical directors and the managing directors of the various blood banks have cooperated in full measure. Their contribution to the over-all state plan is outstanding in California's medical history. Working harmoniously together for the common good, they have set a fine example for others, and have demonstrated to the nation that an integrated non-profit blood bank system is sound, stable, and solvent in blood.

Mrs. Charles D. Hemphill, our administrative assistant, has performed yeoman service. The entire Commission has benefited by her uncanny grasp of the over-all situation; I could not have carried out my task without her loyal, self-effacing assistance. Thanks, Bernice!

What of the future? Time will tell. We can take some pride in the knowledge that our State has a better blood bank system than ever before. Much work still remains to be done, however, before we can truthfully say that there is complete blood coverage for California. That is our goal —with every member's assistance we may reasonably expect to reach that goal in 1951. It is a challenge to Medicine— and I predict *Medicine can do the job.*

Respectfully submitted,

JOHN R. UPTON, *Chairman*

COMMITTEE ON RURAL MEDICAL SERVICE

To the President and the House of Delegates:

The fourth California Rural Health Conference was held in Fresno, January 13, 1951. The conference subject was "Rural Hospital Problems," which was divided into the four subjects of:

1. Prospectus for the Hospital
2. Plans and Construction
3. Governing Body, Hospital and Medical Staff Relationships
4. Problems of Operation

Dr. Neil J. Dau, Councilor for the Fourth District, represented the California Medical Association, and emphasized the importance of maintaining high professional standards, the use of public funds only when absolutely necessary, and that over-building of hospital beds and facilities can be a burden on the community.

Dr. Carroll B. Andrews, conference chairman, pointed out the facts that small hospitals have many peculiar problems which have little or no precedent established, and therefore require careful individual application to be successfully worked out.

The luncheon address by Mr. A. A. Aita, administrator of the San Antonio Community Hospital, Upland, on "The Rural Hospital—A Community Responsibility," emphasized the importance of continually enlisting the community in the various hospital projects. He pointed out that by continuous participation, the public accepted their share of the burden for proper operation.

Summaries of the conference were presented by Von T. Elsworth, research and economic advisor for the California Farm Bureau Federation, who complimented the Committee on Rural Medical Service and the California Medical Association for sponsoring these conferences between the medical profession and farm groups representing the laymen. His pertinent comment was: "The average citizen is also concerned with the problems because he pays the bill."

Dr. Robert Dyar, California Department of Public Health, commended the conference for the attitude of tolerance displayed as the key to the successful solution of the rural hospital problems. Careful consultation, detailed investigations of local conditions and factors involved in the problems, together with the assistance and guidance of the local physicians, was stressed.

The committee is encouraged by the general attitude, the information presented and discussed to the mutual advantage of all who participated, to continue its work in the rural medical service field.

The chairman of the Committee attended the American Medical Association-sponsored National Health Conference at Memphis, Tennessee, February 22 to 24.

Respectfully submitted,

CARROLL B. ANDREWS, *Chairman*

COMMITTEE ON INDUSTRIAL HEALTH

To the President and the House of Delegates:

In the 1950 report of the Committee on Industrial Health we referred to efforts at the national level to clarify the confused situation in regard to standing orders for industrial nurses. We hoped that a satisfactory statement of principles might be forthcoming from the national groups concerned, and failing this we anticipated the formulation of a policy at the state level. Since the national statement did not materialize, a statement of principles was drawn up and was presented to the Council of the California Medical Association in September 1950. Action was postponed by the Council and the statement has not as yet been presented again.

There are approximately 750 industrial nurses employed in the state of California who are working daily among probably half a million employees. We believe this represents a large enough segment of the nursing profession and a large enough segment of the population of California that a harmonious understanding of the principles under which these nurses function is essential to the broad public relations of the medical profession.

The technical language of the Nursing Practice Act and of the Medical Practice Act, and the anomalous situation in regard to the rendering of first aid by laymen, have led to various beliefs as to how far first aid care in industry should be carried out by laymen or by registered nurses. Typical of the confused picture is the erroneous belief, which does exist in some quarters, for instance, that a registered nurse is limited by the Medical and Nursing Practice Act, whereas laymen are not limited in any way.

It is the belief of this Committee that the industrial nurse is a professional person—with professional standards—and that these professional standards should be defined in principle, and that we may count fully on the nurses' associations to support nurses in keeping within these principles and discourage them from violations. It is our belief that these principles can and should be defined and that success in this project will result in an improved relationship between the medical profession and its sister profession, nursing. Long-established precedent in hospital and home nursing has been set up whereby the nurse looks to the physician for orders and guidance, and we feel that it is obligatory that means for establishing or strengthening such guidance for the industrial nurses be found. In the absence of such a statement of policy, beliefs are being implanted by pamphlets and educational literature from other agencies and from other states, which may not be in harmony with the beliefs of the California Medical Association. In the absence of a yardstick established by the California Medical Association, it is impossible to evaluate such material with any degree of assurance.

We again emphasize that the standing orders for industrial nurses or some other authoritative guides as to ethical procedures, have been requested by the nursing organizations in order that they may keep within safe and ethical limits of their field. At present, in many instances, they are subject to pressures from various sources to exceed the proper responsibilities of the nursing profession. With a clear-cut authoritative definition to refer to they will be in a position to insist on referring to the medical profession those patients who should have medical care. The nurse in industry who, with or without conscious intent, may have been encroaching on the practice of medicine, however, will have no excuse for continuing to do so in the face of a code of principles when and if it is issued and supported jointly by the medical and nursing professions and by industry.

We believe it should also be kept in mind that during World War II the tremendous pressure for production and the shortage of medical men resulted, through expediency, in an increased acceptance of medical responsibilities by nurses which should have been abandoned when the urgency was ended. In view of the fact that at the present time it appears possible that we may be confronted with a similar situation, we believe that the principles should be stated now, to stand as a water-mark to return to should the flood of war again engulf us.

Your Committee feels that the presence of a statute is not in itself an educational program. Legal language, while specific, is subject to various interpretations and we feel that education by a statement of principles is absolutely essential for true, long-term education. Furthermore, your Committee believes that laws follow public beliefs, and do not create them. Therefore, we believe that it is to the interests of the California Medical Association and of the nursing organizations not to abandon efforts to find a statement of principles or a code of ethical practices which is acceptable to both professional groups. Efforts to formulate such a policy are continuing at the national level and it may be that this year will see such a statement issued jointly by the American Medical Association, the American Association of Industrial Nurses, the American Association of Industrial Physicians and Surgeons and other interested national groups. Should such a statement be issued it may be evaluated by the California Medical Association as to its worthiness of their approval.

Failure of such a statement to be issued at the national level or to be accepted by the California Medical Association should it be issued, would, we believe, call for another effort to prepare another statement which would be presented for consideration by the Council.

Ultimately, we believe, the Committee on Industrial Health of the California Medical Association will take a part in an all-over program—statewide—by many agencies and employers and employee groups, to improve industrial health conditions. This will demand cooperation in various areas with many official and non-official agencies. We do not anticipate progress being made in this direction, however, until we have a healthy working relationship established between the industrial nurses and the physicians in their own fields, which will free their attention so that they may concentrate on jointly contributing to broader fields of industrial health.

If your Committee on Industrial Health is perpetuated, we believe its efforts should continue to be channeled toward clarifying the field of function of the industrial nurse by a positive acceptable statement and eliminating present confusion and bewilderment.

CHRISTOPHER LEGGO, *Chairman*

SPECIAL COMMITTEE ON C.P.S. ADMINISTRATIVE CHANGES

To the President and the House of Delegates:

The committee appointed by you to "look into certain aspects of the administration of California Physicians' Service" met at the St. Francis Hotel, San Francisco, on July 9, 1950. All members of the committee were present. Present by invitation were William L. Bender, M.D., Sidney J. Shipman, M.D., C.M.A. Council Chairman, and Henry L. Gardner, M.D., Secretary C.P.S.

The letter appointing this committee was somewhat indefinite, but the committee decided to limit its deliberations to the consideration of the advisability and desirability of the establishment of a special committee of C.M.A. similar to the coordinating committee recommended by Dr. Bender in a resolution submitted to the C.M.A. House of Delegates in 1949.

The committee was informed that Dr. Bender's resolution was illegal in that it sought to put compulsion upon the Board of Trustees of C.P.S. Any similar committee, therefore, must depend entirely upon voluntary cooperation of the Board of Trustees of C.P.S. This committee feels that this cooperation would be forthcoming.

After considerable discussion the committee recommends the creation of a liaison committee of C.M.A. to work with the Board of Trustees of C.P.S. in an advisory capacity in matters of policy of far-reaching economic and political import.

The committee further recommends that this liaison committee shall be composed of the President of the C.M.A., who shall act as chairman, the President-elect of the C.M.A., the Speaker of the House of Delegates of the C.M.A., the Chairman of the Council of the C.M.A., President of the Board of Trustees of C.P.S., the chairman of the C.M.A.

Legislative Committee, and two members of the House of Delegates who shall hold no other C.P.S. office, to be nominated from the floor of, and elected by the House of Delegates for a term of two years (excepting that one of the initial members shall be elected for a one-year term), to serve no more than two consecutive terms. Since the meeting of this committee a communication has been received from Dr. Bender suggesting the addition of the immediate Past President of the C.M.A. to the membership of the liaison committee. This was not passed on by the entire committee, but seems like a good recommendation to the chairman.

In recommending selection of these top level officers of C.M.A. as the nucleus of this liaison committee, we were of the unanimous opinion that only members who had had years of close contact with the administrative problems of both C.M.A. and C.P.S. would have sufficient background, knowledge, and experience in these matters to make the committee function efficiently.

Respectfully submitted,

ORRIN S. COOK, *Chairman*

ANNUAL REPORT OF THE CANCER COMMISSION

To the President and the House of Delegates:

The Cancer Commission has conducted an extensive program of cancer conferences throughout the state during the past year. At the beginning of the year the opportunity of a conference was offered each county medical society in the non-metropolitan areas. Emphasis, however, was placed on developing regional conferences (15 of which were originally planned). Many members of the California Medical Association participated in these conferences as guest speakers. The expense has been shared by the California Medical Association and the California division of the American Cancer Society.

The program for 1951 is to schedule "Cancer Programs" in each of the county medical societies at least once during the year on the afternoon and evening of their regularly scheduled meeting date.

In June 1950 Dr. Frederick R. Hook, medical director of the Cancer Commission, became ill, temporarily interrupting an excellent program of professional educational activities which he had been carrying out. His resignation was accepted effective September 1.

Succeeding Dr. Hook as medical director of the Cancer Commission is Dr. Franklin C. Hill, who assumed his duties October 1. Dr. Hill had recently been placed on the retired list of the Navy Department, his last assignment having been as medical officer in command of the U. S. Naval Hospital, Long Beach.

Refresher courses for practicing physicians were held last February in Los Angeles and Oakland. These courses were co-supported by the national office of the American Cancer Society, which paid the expenses of three participating Eastern speakers for these programs. For 1951 it is planned to omit refresher courses in these metropolitan areas, except for support of a refresher course for dentists in Southern California (San Diego Dental Society, February 24) and the program of the alumni of the College of Medical Evangelists in Los Angeles in March.

The present edition of "Cancer Commission Studies" which was completed last year has been distributed to the physicians of California. In a number of instances a considerable number of copies have been distributed to physicians out of the state. Comments have been laudatory. Again, grateful recognition is given to the authors of these studies and to the editorial committee consisting of Doctors Dobson (chairman), Berne, Pflueger and Kenney for their work.

At the present time there are about 62 tumor boards in California, of which 49 have been approved by the Cancer Commission. A majority of these boards have been visited and inspected by Dr. Hill since last October. Those boards which have not been approved are being encouraged and given all assistance possible in their efforts to meet the Minimum Standards for Approval established by the Cancer Commission. Approval by the Cancer Commission is a prerequisite before financial support can be given to a board by the American Cancer Society.

The Cancer Commission is maintaining its close cooperation with the California division of the American Cancer Society, and members of the Commission are taking an active part in the board of directors and executive committee and all other committees at the state level. The Commission commends the exceptional lay leadership in this organization for their rare judgment and intensive work and for their fine cooperation with the medical profession. The Commission, working jointly with the California division, agreed to share the costs in distributing the new bimonthly journal, *CA*, to 4,600 practicing physicians in the state. Initially, this journal will be distributed chiefly among those physicians who are in general practice. *CA* is a new journal of the American Cancer Society designed to keep busy practicing physicians up to date with newer developments in not only research but diagnosis and treatment. The first number is datelined November 1950. At the end of a year a survey will be conducted to determine usefulness of the journal and possible wider distribution. New professional films on cancer developed by the national office of the American Cancer Society in cooperation with the National Cancer Institute have been shown before a number of professional audiences and county medical societies this past year.

Additional county branches of the American Cancer Society have been organized in both the southern and northern counties. Before a county branch can be organized it must have the approval and cooperation of the county medical society in each instance, for the medical policy and projects of the county branch must have the full approval and endorsement of the medical profession. The state division recognizes that cancer control is both a medical and community problem and that any county branch will succeed in direct proportion to the interest and cooperation of the county medical society. The function of the county branch in making the public cancer-conscious and sending potential cancer patients early to their own physicians requires the best and most energetic medical leadership in any county for its accomplishment. The Cancer Commission urges the cancer committee of each county medical society to give continued untiring support to the county branch of the American Cancer Society. The lay educational program is bringing definite and measurable results.

In order to keynote the important role of the county medical society in the cancer control program and to serve as a guide in the cooperative relationship with the local county branch of the Cancer Society, the Commission has re-edited and brought up to date the brochure, "The Cancer Committee of the County Medical Society." This new edition became available for distribution January 1, 1951.

The Cancer Commission continued to study the problem of early cancer detection, reaffirmed its stand against "Cancer Detection Centers," and reemphasized its belief that each private physician's office should be a center for detection of cancer. At the January 19 meeting of the commission in Los Angeles, the report of Dr. Garland's committee on "Cancer Detection in the Private Physician's Office" was approved. This provides for a realistic approach with emphasis placed upon a routine examination of accessible sites for the possible presence of incipient or established neoplastic disease. It is hoped that the plan will be given a

trial run during the coming year by one or two "pilot" county medical societies, after which the experience will be evaluated by the Cancer Commission for possible expansion on a statewide level. The plan places responsibility for early detection of cancer in the hands of the practicing physician in his private office.

Two pre-convention conferences will be held on May 12, sponsored by the Cancer Commission. The Conference on Microscopic Tumor Pathology will place emphasis upon tumors of the intestinal tract. David A. Wood will be the moderator. James Kahler, chairman, and Ernest M. Hall, secretary (with the assistance of the Los Angeles Tumor Registry) are preparing the material for this conference. Members of the C.M.A. who are interested in the surgical pathology of intestinal tumors may avail themselves of this opportunity. The pre-convention Conference on Radiology is being prepared by R. F. Niehaus, chairman, and Merrell Sisson, secretary. This conference will be divided into sections on diagnosis and treatment. It also is available to members of the C.M.A.

The Cancer Commission has taken interest in and given support to the recently created Los Angeles Tumor Registry. This registry deserves much credit for the excellent preparation of lantern slides and microscopic slides used at the last two microscopic conferences sponsored by the Commission in San Diego last April and San Francisco last December.

The Commission sincerely appreciates the cooperation and support of the President and the Council in their effort to represent the California Medical Association in the cancer control program.

Respectfully submitted,

LYELL C. KINNEY, *Chairman*

INDUSTRIAL ACCIDENT FEE SCHEDULE COMMITTEE

To the President and the House of Delegates:

The original report of this committee was published in CALIFORNIA MEDICINE, Volume 73, November 1950, pages 447-449. The following summary presents the activities of this committee to present date (February 8, 1951).

A meeting of the advisory committee of the Industrial Fee Schedule Committee was held at the Biltmore Hotel on Friday, November 10, 1950. Several subjects were presented for general discussion, among them that of multiple schedules. It is becoming apparent that there are a number of these schedules being printed in the state having to do with medical and surgical fees. Some have been made on an indemnification plan entirely and it is pertinent that many of these new schedules are based on a much higher fee level than the industrial schedule. The schedules we are most interested in are those being formed by the various labor unions. These plans are on a pure indemnification level whereby the employer is paying for the coverage for the laborer and, with an additional fee, coverage is being extended to the members of that laborer's family. The insurance carriers are writing the schedule any way that the labor union wishes to have it written and adjusting their premiums accordingly.

We discussed at length the recent successful appeal on the part of the insurance carriers before the office of the Insurance Commissioner of the State of California, wherein they requested an increase in Workmen's Compensation insurance rates in the amount of 6.86 per cent. This application was based on the claim that the 1950 schedule of medical and surgical fees was causing an increase of 2.45 per cent in premium costs and that the new permanent disability ratings warranted a 4.41 per cent premium increase. A hearing on this matter was held in San Francisco and a second hearing in Los Angeles. The application was based on the claim that the 1950 schedule of medical and surgical fees was causing an increase of 2.45 per cent in premium costs and that new disability costs warranted a 4.41 per cent premium increase.

The Insurance Commissioner granted this increase in premiums to the compensation carriers.

In presenting their testimony in support of their application the carriers acted largely through the California Inspection Rating Bureau, a quasi-official organization maintained by the carriers themselves and recognized as a fact-finding body by the Insurance Commissioner in setting premiums for this type of business. The California Inspection Rating Bureau presented a number of exhibits in support of its testimony and we have had the opportunity to examine and analyze the figures on thes exhibits.

Without attempting to go into an analytical study of these figures, we can give you the underlying figures which indicate what portion of the premium dollar is actually paid to physicians for professional service. Some of these figures are:

Annual compensation insurance premiums	$100,000,000
Annual losses (1947 basis)	50,482,230
Medical costs (1950 basis)	18,125,348*

The California Inspection Rating Bureau presented as its principal exhibits on medical costs a study made of the payments to physicians and others for medical and allied services for the month of June 1950, as compared with an average month of 1947, when the 1946 schedule of medical and surgical fees was in effect. In making this study the bureau selected the ten largest compensation carriers and had daily study sheets prepared in the offices of each to show the payments to physicians on each day as compared with what the comparable payments would have been under the 1946 fee schedule. Thus they arrived at a straight comparison of medical fees under the old and the present fee schedules.

In all, these ten carriers wrote 80.6 per cent of the compensation premium volume in California and accounted for 80.3 per cent of the losses, which indicates a large sampling of the entire industry. Applying their premium percentage, we find that they wrote $80,600,000 in premiums.

In making the comparison of medical costs, the exhibits show that for June 1950, a total medical cost of $1.270.143 was incurred by these ten carriers, compared with $1,223,992 for the average month of 1947, or an increase of 3.77 per cent. If we apply that percentage increase to the total 1947 medical cost figure of $14,687,909, the indicated 1950 total medical cost would be $15,241,643. If we then apply to that total medical cost the percentage of 60.43 per cent shown for June 1950, as the percentage of total medical costs paid to physicians, we arrive at, roundly, $9,000,000 to be paid to physicians in 1950 for their professional services. This would constitute roundly 11 per cent of the premium income of this group of carriers.

Figured another way: The carriers show that actual payments to physicians for June 1950 were 12.54 per cent higher than they would have been under the 1946 schedule of medical and surgical fees. When this increase is added to costs for hospitalization and other items used in compiling "total medical costs" the increase of 1950 over 1947 comes to 6.92 per cent. (This figure is arrived at by using one set of hospital and other cost figures for both periods; there is no indication that these are actual costs in both instances.) Thus the increase in payments to physicians is used to ask for a 2.45 per cent increase in premium (which would indicate that physicians' fees alone accounted for 19.6 per cent

*Includes payments to hospitals and others; payments to physicians indicated at 60.43 per cent of total medical costs in one place and 58.1 per cent in another.

of total premiums) while in the exhibits themselves the carriers base their request for increased premiums on the increase in total medical cost. If we take 60 per cent of 19.6 per cent (the doctor's portion) we would arrive at 11.76 per cent of total premiums paid to the doctors.

In several places in the exhibits it becomes apparent that the doctor is actually paid for professional services somewhere between 55 per cent and 60 per cent of "total medical costs" and that "total medical costs" account for about 20 per cent of total premiums. Thus the doctor receives between 10 per cent and 12 per cent of the total premiums paid by policy-holders for their compensation insurance.

This figure has been about what we have calculated for some time and about what the latest annual report of the State Compensation Insurance Fund indicated. The insurance carriers have consistently lumped together payments to physicians, to hospitals and others under the category of "total medical costs" and have indicated their inability to bring out as a separate item the total amount paid to physicians or the ratio of such amount to premiums. However, the exhibit figures seem to definitely pin down the portion of the premium dollar which is actually paid to physicians for their professional services.

The foregoing observations stimulated a good deal of comment, but none of us on the committee felt that we were able to completely digest the material or to interpret it accurately. We felt that additional help was necessary and Dr. Madsen suggested that actuarial counsel be employed to investigate the whole matter of fees for this committee. He felt that the only approach which would be logical would be to base a study on the basic living standard and to measure the changes that have occurred between the date when a schedule was first approved by the Industrial Accident Commission and 1950.

Your negotiating committee, consisting of Dr. Carson, Dr. Maner, and the chairman, met with the insurance carriers in San Francisco on December 7, 1950.

The entire morning session was spent primarily with a discussion on the part of the various insurance carriers regarding simplification of the insurance report forms and simplification of the entire secretarial aspect of conducting a practice in industrial medicine or surgery. The insurance carriers have been very interested in this phase of the work and presented a plan to adopt four standard forms: (1) an initial report, (2) a small weekly compensation order which is to be made in duplicate postcard form so that it is very simple to figure out; (3) a monthly or semi-monthly supplemental report to indicate the progress of a case; and (4) a final report and bill.

The Industrial Accident Commission has taken an interest in this same plan and it has designed three simple forms for indicating the progress of any injury which would lead to a permanent disability. All physicians who do industrial medicine or surgery will immediately see the value of these various changes in eliminating a great deal of extra secretarial work and still furnishing a very complete report to the various insurance carriers.

The matter of the attitude of medicine and the insurance carriers toward the inquiry from the Senate Interim Committee was discussed at length. Mr. Snow spoke for the insurance carriers. His comments were to the effect that in general the insurance carriers did not wish to have any further authority delegated to any governmental agency which might influence their ability to conduct their business as an insurance company. He felt that the government perhaps had too much influence upon the insurance business now. He mentioned that this move might be just another step toward not only socialization of medicine, but socialization of insurance in general.

As he talked, we presented this problem that perhaps we, as doctors, would be in a much better position to negotiate with an impartial group such as the Industrial Accident Commission than we have been with the insurance carriers in the past. We brought to his attention the fact that under existing laws any change in the industrial fee schedule would not be compensated for by an adjustment of premium rate until three years of experience had elapsed. This law, therefore, makes it impossible for the doctors of the State of California to negotiate an increase in fees with the 168 companies in the State of California who are writing compensation insurance. We suggested that if the insurance companies wanted to show good faith perhaps it would be wise for them to suggest or actually initiate legislation through the Legislature to allocate to the Insurance Commissioner of the State of California the power and ability to adjust changes of premium rate immediately upon any change in the fee schedule. As a protection, perhaps, the adjustment of the premium rate itself might be made retroactive over a period of three years, but at least it would enable the doctors and the insurance companies to negotiate directly without the bloc of the Insurance Commissioner's office preventing such negotiations from ever being accomplished.

We presented to the insurance men our request for an increase in fees based on the changes suggested at the meeting of our entire group on September 9, 1950, as follows:

First visit and report		$ 6.00
Follow-up office visit		4.00
Hospital visit		5.00
Home visit		6.00
Detention with a patient in critical condition beyond reasonable period	per hour	10.00
Detention after 7 p.m.	per hour	15.00

In offering these fees we agreed as doctors that all charges for the auxiliary office services incidental to an office visit should be eliminated. Surprisingly, this is a rather difficult thing to define accurately, but we implied, for example, that the injection of penicillin, intravenous injection or intramuscular injection, should be included with the charge except for the cost of medication supplied. We also suggested that a possible rewording of the schedule could be accomplished to allow for a lower fee for non-professional services which might include, for example, such services as those in which a patient reports to an office nurse only for minor dressings or some other minor procedure which does not require the presence or attention of the attending physician.

We were asked to comment upon or suggest some method of control over the recent increases that have been made by hospitals in the rates for professional services. A good many hospitals in this state have arbitrarily set up their own fees for services such as x-ray and laboratory, and have been demanding, and in most cases getting, fees which are above the present industrial rate schedule. Our comment was that we had no authority over this matter at all.

In accordance with the suggestion of Doctor Leo Madsen and of the advisory group the problem of employment of actuarial counsel was presented to the Council of the California Medical Association at its meeting in Los Angeles on January 27, 1951. The Council has appropriated funds to be allocated for use in employment of such counsel. No definitive plan has been made as yet but this matter will be worked out and we should have something concrete to show for our effort by the time of the Annual Meeting in Los Angeles, May 13-16, 1951.

Respectfully submitted,

FRANCIS J. COX, *Chairman*

ANNUAL COUNTY MEDICAL SOCIETY REPORTS

FIRST DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties.

John D. Ball, Santa Ana, *Councilor.*

Imperial County Medical Society

During a period of 13 weeks the county medical society employed a local radio station to broadcast five-minute news briefs once a week in order to present organized medicine's side of the story to the people and to combat state medicine at the local level; these broadcasts have been enthusiastically received.

The members of the medical society have had the privilege of becoming senior members of and organizing the first staff of the very splendidly equipped and elaborately furnished Pioneer Memorial Hospital recently opened near Brawley.

The society holds its regular meetings the second Tuesday of each month at 8 p.m. at the Pioneer Memorial Hospital. The scientific program is followed by a business meeting. At the December meeting the society adopted a constitution and by-laws including the formation of an executive council which it is hoped will relieve the society as a whole of a lot of detailed administrative time-consuming work.

ERNEST BROCK, *Secretary*

Orange County Medical Association

The year 1950 has seen us safely over the problems resulting from converting our association from its traditional pattern to that of a business-like organization, functioning along clearly defined public relations lines and centralizing its activities through the services of an executive secretary.

This first full year under the new plan has proved the wisdom of those in our association most responsible for its adoption. In the first place, the onerous detail work no longer falls to the officers and to committee chairmen. They are free to concentrate on policies and courses of action, leaving the routine but vitally necessary steps which follow to the headquarters office staff.

We also are in much better position, with a central office, to keep the press aware of information pertinent to the public health and welfare and to correct, with a minimum loss of time, misinformation not in the public or professional interest.

Our 24-hour telephone service through which the services of a physician are available has handled more than 200 calls from the public and from civil authorities without once failing to supply a doctor in an emergency. Without such service, any one of those calls could have resulted unfavorably.

Our association has been called upon several times to help clarify misunderstandings between patients and doctors and, through active committees, has been effective in protecting both the doctor against unscrupulous patients and patients against inconsiderate or unethical doctors. And our bureau of medical economics has come through its reorganization stage not only in sound financial position but also with definite proof that it is an actively functioning unit in our long-range medical public relations program.

CHAD M. HARWOOD, *Secretary*

Riverside County Medical Association

The annual doctors and wives' banquet of the Riverside County Medical Association was held December 16 at the Racquet Club in Palm Springs.

The association meets the second Monday of each month at the Mission Inn in Riverside. A scientific program is presented after the business session, and light refreshments are served at the conclusion of the evening.

A monthly bulletin of pertinent news and information for the members is published each month.

RICHARD N. BOYLAN, *Secretary*

San Bernardino County Medical Society

Our membership continues to increase. We now have 239 active and seven retired members, in addition to whom we also have a number of new applicants for admission.

One of our biggest developments during the past year has been the blood bank. After considerable investigation, we have decided to establish our own blood bank with the Riverside County Medical Society. This is to be centered in San Bernardino, and will follow the plan as outlined by the California Medical Association's Blood Bank Commission.

The building has been secured, and the process of remodeling is progressing. A manager has been secured, and we confidently believe that the blood bank will be in full operation by March 1, 1951.

The plans for raising the money have been formulated, the doctors having obligated themselves for about $10,000 and the balance is to be collected by public subscriptions.

This is to be a completely non-profit community enterprise, under the control and management of members of each component medical society. It will be fully staffed with mobile units and will serve both counties, which will participate with ten men on the board of directors, five doctors and five laymen. Six of the board members will be from San Bernardino County, and four from Riverside County.

The Woman's Auxiliary is going to be extremely active in helping with the blood bank. They have adopted this as their main project, and everything points toward a complete success.

CARL M. HADLEY, *Secretary-Treasurer*

San Diego County Medical Society

Perhaps the biggest problem faced by the San Diego County Medical Society in 1950 involved the establishment of the San Diego Blood Bank, which commenced operations December 1. Sponsored by the California Medical Association and this society, the bank is now serving the community in a very commendable manner.

Our council and blood bank committee spent many hours in working out necessary details, but we believe the time was well spent.

As in the past several years, particular stress was laid upon public relations and excellent progress was made. Blue Cross-Blue Shield and the California Medical Association sponsored an intensive publicity campaign here February 15 to March 1 announcing the availability of individual coverage in San Diego County. Ads, pictures and a great deal of reading copy appeared in every newspaper and the public response was beyond our fondest hopes.

A local committee of physicians staffed the press rooms during the C.M.A. convention in May to interpret the papers for the press. Results were excellent and many appreciative letters and comments were received from the reporters and scientific writers.

A society blood bank exhibit was installed at the county fair here from June 28 to July 9, also at the Frontier Homes Health Carnival on August 26.

Sixty-five radio programs were presented during the year and a considerable amount of space was devoted to society activities by local newspapers.

Our speakers' bureau continued active throughout the year, addressing groups throughout the county on socialized medicine and many other topics.

Our society committee has played a leading role in the local disaster council and devoted a great deal of time to making preliminary plans. This phase of our community activities will demand an increasing amount of our attention in 1951.

W. H. GEISTWEIT JR., *Secretary*

SECOND DISTRICT

Los Angeles County.

Jay J. Crane, Los Angeles, *Councilor.*

Los Angeles County Medical Association

The year 1950 came to a close with the threat of war and the possibility of an atomic attack, keeping the Los Angeles County Medical Association through its hard-working, hard-hitting committee on civil defense working hundreds of hours overtime to prepare this area to the utmost should war reach us in Los Angeles.

Our advisory committee to selective service, activated late in the year, quickly met the emergency caused by the draft of physicians to the armed services. Another special committee, designed to advise with reserve officers when they are called to active duty, is meeting its responsibilities in this work.

The threat of war also brought to the Association a responsibility in helping to meet the demand for blood. A special blood bank committee of the Association was formed to meet with and advise and assist the Red Cross

blood bank program and other blood bank operations within this county. This committee has held numerous meetings, working out a program that is hoped will find this area prepared to supply its share of blood to the military and to the civilian population in time of emergency.

The total membership of the Association at the end of the year reached 4,996, an increase over 1949. This increase in membership makes it mandatory for the Association to consider new quarters, including new library facilities. The present library and administration building, built when the membership had just reached 2,000, are now totally inadequate to meet the demands of a larger membership.

During the year the Association bought property on Westlake Avenue near its present buildings and through the sale of other land finds itself in possession of sufficient funds to seriously consider plans for new buildings.

The increase in membership and the change in the ratio of members practicing within the city and members practicing in the county area outside the city has called for a revision of the by-laws of the Association. A by-laws committee has been working on this revision toward an end that will find our by-laws justly meeting the demands of truly representative government.

A factor of vital importance to the people of Los Angeles County, involving as it does a very important factor of health, led to the creation of a very active committee on smog. The chief purpose of this committee is to determine the effects of smog on the health of our people and to bend every effort toward bringing this important phase of the smog problem to the attention of the proper officials and possibly to the people of Los Angeles County.

The Los Angeles County Physicians' Aid Association, created some years ago by the Los Angeles County Medical Association, toward the end of the year purchased a mansion at 3500 West Adams Boulevard, Los Angeles, for a home for those unfortunate elderly members of the Association, some of whom already are domiciled there. The property offers spacious landscaped grounds with the opportunity of adding a large number of bungalows as the need for further domiciliary care develops.

The Woman's Auxiliary of the Association as in the past has rendered valiant service in the interest of public relations. The Association has plans for greatly augmenting this important work by the Auxiliary.

Public relations work in general has been carried on much as in the past, the Association sponsoring three radio broadcasts a week, and during the early summer presented a total of nine television shows. A fine liaison has been maintained with the Los Angeles Chamber of Commerce, our city and county health departments, and the department of welfare, and with the Metropolitan Welfare Council of Los Angeles and with various other organizations of Los Angeles County.

Postgraduate work, as last year, continued in the form of weekly breakfast meetings at which practical scientific papers are presented under the guidance of Louis J. Regan, M.D., director of medical relations.

R. O. BULLIS, *Secretary*

THIRD DISTRICT

Inyo-Mono, Kern, San Luis Obispo, Santa Barbara, and Ventura Counties.

Harry E. Henderson, Santa Barbara, *Councilor.*

Inyo-Mono County Medical Society

The year 1950 has seen nothing unusual in our society.

In the field of public health there has been a marked improvement, in that the full-time health officer, with adequate budget, has Inyo County now up-to-date in this important activity.

Population of the Inyo-Mono area is increasing, this in turn resulting in our doctor population growing to 14. We have four active dentists, and need about two more.

L. S. BAMBAUER, *Vice-President*

Kern County Medical Society

Time and the efforts of the doctors of the Kern County Medical Society have worked hand in hand during 1950. The gains of the past three years have been held securely and strengthened by time to a point approaching hoped-for permanence.

The usual implements of public relations have been used to good advantage throughout the year: radio programs, speakers' bureau, newspaper publicity, county fair exhibits, distribution of literature, personal contact and various others.

In the county fair endeavor, cooperation with health agencies of the county in a Hall of Health display has made new friends and made the medical society services better known to not only fairgoers but agency workers as well.

To provide postgraduate education opportunity, scientific programs have been scheduled monthly for the regular society meetings, at which many excellent medical speakers have presented papers. Furthermore, a cancer symposium was made available to the doctors of the county and in addition a postgraduate assembly, covering various medical subjects, was planned and presented.

The hospital building committee of the society proceeded with a hospital survey that has long been contemplated and from which constructive plans may emerge.

The blood bank committee took the initial steps toward establishment of a community non-profit blood bank along lines recommended by the Blood Bank Commission of the California Medical Association; consummation of the plan will undoubtedly be seen before July 1, 1951.

A public response (grievance) committee has been established and will be available, if needed, to adjust the doctor-patient differences that might arise in the next year. It has been set up in accordance with recommendations of the American Medical Association and the California Medical Association for county societies.

A military advisory committee and a medical emergency committee were appointed and activated to meet new demands on medical leadership.

The Kern County Hospital situation that has been the source of much concern in past years slumbered throughout 1950 in much the same fashion as an inactive volcano. Landscaping to hide the scars and reconstruct the damage is now very definitely within the realm of feasibility.

The popularity of the medical profession in Kern County is very definitely on the upswing, and should continue uninterruptedly at increased tempo.

The medical economics council has retained and strengthened its original services with the addition of some new accounts, making the prospects of additional revenue for 1951 very probable.

A California Physicians' Service seminar was arranged for the training of the doctors' office assistants in California Physicians' Service procedures.

Individual doctor activity in the field of politics was especially strong and productive.

ROBERT L. DAY, *Secretary*

San Luis Obispo County Medical Society

The San Luis Obispo County Medical Society held nine regular scientific meetings, two social meetings, and one postgraduate meeting during 1949. Meetings were well attended and the scientific discussions by out-of-town speakers were well received.

The San Luis Obispo County Medical Society donated $1,000 to the organization of the Tri-County Blood Bank and has furnished its full cooperation to the establishing and functioning of this excellent facility.

The county medical society has a procurement and assignment service committee which has been functioning actively and cooperating with the State Association.

Five applicants were elected to membership in the society.

JOHN H. WOODBRIDGE, *Secretary*

Santa Barbara County Medical Society

The Santa Barbara County Medical Society's membership total reached the figure of 148 in 1950. During the year eight new members were elected; four members transferred elsewhere; three members resigned; one member retired; two members died; seven new members will be elected during the next four months.

Our meetings are held the second Monday of each month in Bissell Auditorium in the Cottage Hospital. The speakers have been outstanding and have contributed greatly to the enjoyment of the members by the excellent presentation of their subjects. The list includes such well known men as Doctors Edward W. Boland, Frank Gerbode, E. Kost Shelton, Howard P. House, and Donald Cass.

The movement which was started at the end of 1949 to create a blood bank for the tri-counties of San Luis Obispo, Ventura and Santa Barbara is now an accomplished fact, having opened for business on July 1. Due to the enthusiasm of the workers under the leadership of Dr. Paul L. Ashton, president and director of the Tri-Counties Blood Bank, the central depot and laboratory is now firmly established and working efficiently for the benefit of the communities and the medical profession

which it is intended to serve. Members of the society take turns in being present during bleeding hours. The woman's auxiliary was responsible for raising the money with which to purchase the walk-in refrigerator, and the women do volunteer clerical, procurement, and laboratory work and may be called upon by the chairman of the steering committee at any hour.

The Cancer Commission of C.M.A. presented a splendid program through many qualified speakers who outlined the diagnosis and treatment of many forms of the disease. Dinner at the Montecito Club preceded the evening session; a large and appreciative audience was in attendance. For two days the woman's auxiliary manned a table in the city for the cancer drive.

A group of outstanding teachers from the College of Medical Evangelists presented an excellent program at the postgraduate assembly on October 12 and 13. The sessions were well attended and the consensus of opinion was that this assembly was a very successful one. Dr. Louis J. Regan was the speaker at the banquet on the opening night to which the wives of the members were invited. The woman's auxiliary helped with the registration for the assembly and handled the luncheon tickets.

The Santa Barbara County Medical Society now looks forward to a busy and interesting year under the guidance of our new president, H. V. Findlay, and president-elect, G. H. Coshow. Our officers elected at the December meeting were: vice-presidents at large, L. E. Heiges and L. H. Streaker; secretary-treasurer, L. M. Nelson; delegates, A. B. Wilcox (two years), J. G. Campbell (one year), L. M. Nelson (one year); alternates, R. W. Lambuth (two years), Max Hammel (one year), D. F. McDowell (one year); council, H. V. Findlay, L. E. Heiges, R. L. Reeves, W. J. Sheehan and H. E. Henderson.

LAWRENCE M. NELSON, *Secretary-Treasurer*

Ventura County Medical Society

The Ventura County Medical Society held ten meetings during 1950. Meetings are held on the second Tuesday of each month at the Colonial House in Oxnard. The meetings are preceded by dinner. The first meeting following the Annual Convention of the California Medical Association was devoted to the report of the delegates. The proceedings of the House of Delegates and the Administrative Members of California Physicians' Service were presented and discussed. We were honored by a visit from Dr. Donald Cass, President of the C.M.A., who discussed public relations with us.

In conjunction with San Luis Obispo and Santa Barbara county medical societies, a Tri-Counties Blood Bank has been established. It is supplying our local needs in a satisfactory manner and is also collecting blood for the American Red Cross.

The hospital bed situation is improving. The Foster Memorial Hospital of Ventura is completing a 20-bed addition which will be ready for occupancy about February 1, 1951. The money has been raised for a 75-bed addition to the St. John's Hospital in Oxnard. It is anticipated that construction will be started in the near future. Bonds have been approved for a 75-bed addition to the Ventura County Hospital. Construction of this addition should be started this fall.

This addition of these beds to the present hospital facilities will probably create a critical shortage of nurses, as there has been some difficulty keeping the present facilities staffed with properly qualified nurses.

A committee on public relations has been appointed with C. A. Smolt, of Ventura, as chairman. We hope to initiate a sound public relations program which is compatible with our rather limited membership.

The following officers were elected to serve for the year of 1951: president, J. W. Moore, Ventura; vice-president, J. R. Monohan, Oxnard, and secretary-treasurer, A. A. Morrison, Ventura.

A. A. MORRISON, *Secretary*

FOURTH DISTRICT

Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties.

Neil J. Dau, Fresno, *Councilor.*

Fresno County Medical Society

Every phase of the Society's program during 1950 was directed toward the strengthening of internal relations and improved public relations. Early in the year the Society adopted a new constitution and by-laws which had been prepared during the preceding year. The first annual medical and surgical institute, co-sponsored by the C.M.A., was held in November. A C.M.A. Cancer Commission program was presented in September.

A local chapter of the American Academy of General Practice received its charter in October. The society cooperated with the C.M.A. and A.M.A. in the National Education program. Our Speakers' Bureau has been active and an increasing number of talks has been given by Society members on scientific and medical-economic subjects. In addition, more than 20 addresses on the subject of socialized medicine were presented throughout the Central Valley. The speeches indicated the constructive program which the Society had accomplished and were based on the premise that such was in the public interest and therefore had public relations values.

Our Committee on Professional Relations continues to serve as a judicial body in indicating, to the profession and the public, various standards of medical practices and procedures in the community. Throughout these hearings and dealings with the public and the profession, the committee has made a serious and conscientious effort to (1) assure the public of a fair hearing and make no attempt to whitewash the profession, and (2) assure the profession that no arbitrary rulings or undue pressure will be exerted which would adversely affect the physicians' individual rights. The Society's efforts to arbitrate complaints from the public have been publicized judiciously and have met with general favor. A sub-committee of the professional relations committee has held a meeting with officers of the Fresno-Madera Pharmaceutical Association and another meeting with the nurses, physical therapists, x-ray and laboratory technicians. Purposes of the meetings were to establish greater rapport among allied professions and to iron out various problems of ethics and procedures.

The Society's office has continued to serve the public in securing doctors in emergencies, arranging for referral of patients to doctors, disseminating data concerning health insurance, medical schools, hospitals, medical society policy, public health matters and the like.

An essay contest in all city high schools was initiated by the Woman's Auxiliary and the Society is offering defense bonds in the amounts of $100, $50, and $25. Subject of the essay was "50 Years of Medical Progress, 1900-1950." The contest closed January 12, 1951, and enjoyed a highly favorable reception from students and school officials.

The Society began the coordination of medical facilities with the civil defense authorities and is cooperating with the Society-endorsed Valley Blood Bank and the Red Cross in the national defense blood program. The Society was effectively represented in drawing up a medical staff policy for the proposed Valley Children's Hospital.

The Society's group malpractice and educational program has been functioning well, as has the health and accident insurance plan.

Press and radio coverage of the activities of the Society and its members has been good.

Monthly scientific programs have been good and attendance has maintained a favorable average. Membership in the Society has increased from 222 to 243 members of all classes.

In the field of public health, an informal survey of West Side migrant labor camps was conducted by members of the Public Health Committee. Many factors contribute to improper health conditions and one of the main problems seems to be camp sanitation and the need for constant supervision of the sanitary facilities in these camps. The Society presented a detailed report at a hearing of the state committee to survey the agricultural labor resources of the San Joaquin Valley. Facilities of the Medical Society have been offered the Fresno County Coordinating Council in its studies of medical problems that arise in this area. Physicians' forms for the physical education remedial program in the Fresno city schools were approved. The Society, along with other groups, recommended to the city commission that a compulsory training course be instituted for food handlers. The program was put into effect by the commission. The Society is represented on the County Health Center steering committee.

In the interest of public health and scientific medicine, the Society has studied and kept abreast of local, state and national legislation and has cooperated with the Public Health League of California, as well as the C.M.A. and A.M.A.

A proposal of our library committee that the library at the Fresno General Hospital be operated jointly with the Medical Society was approved and $500 has been budgeted to carry out the program during 1951.

THOMAS A. COLLINS, *Secretary-Treasurer*

Merced County Medical Society

The officers for 1951 are Dr. J. J. Wolohan, Livingston, president; Dr. Shelby Hicks, Merced, vice-president; Dr. Harry R. Maytum, Merced, secretary-treasurer; Dr. George Pimentel, Los Banos, delegate, and Dr. E. A. Jackson, Merced, alternate.

The following new members were elected or admitted by transfer to the society this year: Dr. Ernest A. Bickell, Livingston; Dr. John East, Merced; Dr. Paul Smith, Dos Palos, and Dr. William H. Curry, Dos Palos.

For the past few months the military advisory committee and civilian defense and disaster committee have been very busy.

Regular meetings are held the third Thursday of each month at the Hotel Tioga in Merced at 7:00 p.m., and visiting M.D.'s are always welcome.

HARRY R. MAYTUM, *Secretary-Treasurer*

San Joaquin County Medical Society

The activities of the San Joaquin County Medical Society have been ably directed during 1950 by President George K. Wever. Several important business matters long pending before the Society have been terminated.

For a period of more than one year study was given to the feasibility of engaging a full-time executive secretary. A great deal of information was acquired and work done by a committee headed by Dr. John T. McNally. A vote taken in February indicated that about two-thirds of the membership favored the plan, while one-third opposed it. A 75 per cent vote in favor of the plan was necessary for its passage. Dr. McNally's committee was instructed to continue its program of study and education and a recommendation was made that another vote be taken when the time seemed propitious.

In April the society approved a plan for group health and accident insurance proposed by Dr. Verne R. Ross of the medical problems committee. The master contract was issued to the society by the National Casualty Company of Detroit with a coverage at a moderate cost to all members 60 years of age or under, who are actively engaged in practice. The first six months of operations have proved the value of the contract. Various plans for group professional liability insurance are now being studied by a committee of which Dr. Emil Gough is chairman.

The local Red Cross blood bank under the direction of Dr. D. C. Harrington has been very busy. Recently about a thousand pints more blood per month have been drawn than in the corresponding month a year ago. A major portion of this blood is being flown to Korea but some is also being processed into plasma and blood fractions to be stored for civilian defense.

The annual series of lectures of the postgraduate study club maintained their usual high standard. Members of the society continued to cooperate with the American Cancer Society in lay education in the various communities. A committee of which Dr. Virgil Gianelli is chairman has outlined a plan for the revision of our constitution and by-laws.

F. A. MCGUIRE, *Secretary*

Tulare County Medical Society

The 77 members of the Tulare County Medical Society enjoyed an exceedingly successful year under the leadership of our president, Dr. Wiley C. Zink.

The society meets monthly at various towns throughout the county. We have been very fortunate during the past year to have excellent scientific programs, most of our speakers being from Los Angeles and San Francisco. In addition to our regular scientific programs, we had a very successful ladies' night dinner dance.

The society has furnished two members to the Armed Forces, Dr. William D. Clinite and Dr. Charles M. McClure.

During the past year a new constitution and by-laws have been drawn up by the officers of the society, and at the present time, have been presented to the society for study to be adopted early in 1951.

Officers elected for 1951 included Dr. James E. Feldmayer as president, Dr. J. H. Brady as secretary, and Dr. Robert D. Karstaedt as vice-president. Drs. Feldmayer and Brady were also elected delegates to the California Medical Association.

JAMES E. FELDMAYER, *Secretary*

FIFTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties.

Hartzell H. Ray, San Mateo, *Councilor.*

Monterey County Medical Society

The society at present numbers 110 active members, and has completed a very satisfactory year under the presidency of Dr. Richard Hane.

A new constitution, designed to reduce the business drudgery for the membership at large, was drawn up and adopted this year.

Dr. Theodore Englehorn is the president for next year to be assisted by Doctor Howard C. Miles as secretary.

LEGRAND G. WOOLLEY, *Secretary*

San Mateo County Medical Society

The year 1950 brought the San Mateo County Medical Society to its greatest growth yet recorded. There were 54 new doctors admitted during the year and the membership stands at 243 (all categories) with 21 on application. This growth has brought the County's physician-patient ratio to one doctor to about 950 persons. During the year the Sequoia Hospital at Redwood City was completed and accepted its first patient in October; work will begin on Peninsula Hospital in March 1951.

A series of interesting and educational scientific programs and some social evening meetings were capped with the annual meeting at which Dr. Harry F. Smith of San Bruno was elected to succeed Dr. Ralph D. Howe as president, Dr. D. W. Boudett moved up from secretary-treasurer to president-elect and Dr. Alf. T. Haerem was elected secretary-treasurer.

During the year a new constitution was ratified and its provides for some new district directors to serve on the board. Elected from District 1 was Dr. George W. Laird; from District 2, Dr. Donald W. Linck, and from District 3, Dr. Frederic P. Shidler.

Growth also made mandatory the election of a new delegate and alternate delegate to C.M.A., so Dr. James S. Edwards and Dr. Bradley C. Brownson were accordingly elected for 1951-52.

The Society's executive office has been operating at constantly increasing tempo and is taking ever larger quarters at its present location. Noteworthy among the many facets of the Society's program has been the guarantee by the membership to provide medical care to everyone irrespective of the patient's ability to pay.

D. W. BOUDETT, *Secretary-Treasurer*

Santa Clara County Medical Society

During the year 1950 the membership concentrated its activities on improving and expanding the programs of membership benefits and public services initiated in 1948 and 1949. Organizational work moved forward with greater smoothness and flexibility due to the improvements brought about through the new by-laws which were adopted in late 1949 and put into operation with the inauguration of the 1950 officers. Practically all society programs function under the responsibility of six major standing committees whose work is generally supervised and "spurred-on" by the executive committee. Except for the summer months, the executive committee maintained an annual record of one meeting per week.

The influx of new physicians opening practice in Santa Clara County did not subside from the record of the previous two years. At the end of the year the membership stood at 343, 36 of whom were elected during the year. In addition there were 33 applications pending for election to membership.

In June the American Newspaper Publishers' Association of New York City announced that the county society's newspaper advertising campaign for the year 1950 had been awarded the distinction of being among the fifty best newspaper campaigns in the nation for the entire year. All classes of advertising, including industrial, automotive, general manufacturing, household products, and retail trade were included in the grouping from which judging of the medical society's advertisements were made.

The society continued to expand and publicize with further newspaper advertising the guaranty of its members to provide the services of a physician in all cases where care was needed, irrespective of the patient's ability, or inability, to pay. Services of the society's fee com-

plaint and service complaint committees were also further publicized.

A code governing relationship between the society and its individual members with lay health organizations was recommended by the public health committee and adopted by the council. The code is an adaptation of that recommended by the California Medical Association for statewide use.

The society operated a blood typing service at the county fair held in September. The booth was an unusual center of attraction, and more than one thousand persons were typed without charge.

The society was unfortunately partially deprived of the services of its president, Dr. Fred Borden, who has been confined to his home since June by illness. The balance of his term was completed by our first vice-president, George W. Waters, whose capable leadership and unbounded energy were acknowledged with praise and appreciation by the membership at the annual December gathering. The year closed with a dinner-dance meeting, held at Hawaiian Gardens in San Jose, which was attended by the largest gathering of members and their wives ever held by the society.

WILLIAM L. MOLINEUX, *Secretary*

Santa Cruz County Medical Society

Dr. D. D. Smith of Watsonville served as our president during 1950 and a very successful year was recorded. As in the past the system of bimonthly meetings was continued. At the January meeting our speaker was Dr. Earl King of the University of California Medical School who presented a paper on "Obstetrical Complications." In March the subject of "Amputations of the Lower Extremity" was presented by Dr. Terwilliger of Stanford Medical School. Dr. Carroll McKinney of Carmel was with us in May and discussed the two subjects "Rheumatic Fever" and "Coronary Artery Disease." The health department took over in July and our speaker, Dr. Sox of the State Department of Public Health, addressed us on "The Relationship Which Exists Between a County Health Department and the Local Medical Society." In September officers of the California Medical Association were with us. We heard from President-elect MacLean, Councilor Ray, Executive Secretary Hunton and Ben Read. Medical-economic and medical-political topics were discussed. The annual business meeting was held in November. Dr. William Kuzell of Stanford Medical School presented a paper on "Treatment and Differential Diagnosis of Arthritis." The paper was illustrated with a movie of an ACTH-treated case.

SAMUEL B. RANDALL, *Secretary*

SIXTH DISTRICT

San Francisco County.

M. Laurence Montgomery, San Francisco, *Councilor.*

San Francisco Medical Society

The big event during the year for the San Francisco Medical Society was playing official host to the A.M.A. convention in June. The meeting was most successful in point of attendance, scientific activities, the Delegates' and Chinese dinners, our souvenir pictorial brochure and the weather.

Membership participation and interest in the affairs of the society increased in 1950. A greater number of members served in our various committees. The section and general meetings on the whole had reasonably good attendance. Most successful were the three dinner meetings at which Frank Lahey of Boston, Paul O'Leary of Rochester and Walter Alvarez of Mayo Clinic were the guest speakers. There seems to be a definite feeling that the scientific meeting should be returned to the society instead of being divided into innumerable small hospital sessions. In fact, a movement was started to modify compulsory hospital meetings which have tended to transgress the boundaries intended and thus competed with society activities.

As the Korean situation worsened and the demands of the armed forces for personnel increased, an armed forces advisory committee was created to hear pleas for deferment by recalled reserve medical officers and, by prearrangement with the Army, to recommend for or against their return to active duty. With the passage of the doctor draft law this committee was made representative of the government to provide similar service to the Selective Service System.

In accordance with the agreement on a national level that all blood programs should be completely integrated in peace and war, the society's Irwin Memorial Blood Bank and the local chapter of the American National Red Cross teamed together in a concerted drive for blood for the armed forces in Korea. Whole blood from our blood bank was flown to Korea on the second shipment to leave this country, making the society's blood bank the first independent one in the nation to send blood overseas. This drive for blood and the excellent teamwork between our society and the Red Cross in striving to attain our mutual goal will continue.

The society is playing a leading role in San Francisco's disaster relief program. Our immediate past president, William L. Bender, was appointed chairman of the "Mayor's Advisory Committee on Medical Matters Relating to Disaster." In collaboration with the society's civilian defense medical organization committee, Dr. Bender and his committee undertook the difficult but necessary task of seeing that every available physician, medical student, dentist, nurse and laboratory technician will be professionally competent in the event of atomic disaster by holding meetings designed to acquaint all professions concerned in the medical aspects of relief with the fundamentals. In addition, at this writing all physician members of this society who filled in and returned civilian defense questionnaires have been assigned by the mayor and his committee to a post to which to report in time of emergency.

A new constitution and by-laws more closely geared to the times was adopted at the 82nd annual election held December 12, 1950. Among the changes wrought by the new governing instrument is the deletion of the word "county" in the society's name; a president-elect has been introduced, the voting members of the board of directors enlarged from 21 to 26 members by virtue of giving officers of the society the right to vote with the board, and the office of secretary-treasurer and editor of the society's publications has been divided into two classifications, namely, secretary-treasurer, and assistant secretary-treasurer and editor.

The revised instrument also stipulates that no member may belong to more than one standing or special committee; the membership and admissions committees have been combined into one admissions committee; the professional conduct committee is changed to professional relations committee and its duties are spelled out in great detail; the size of the cancer committee is specified, which the old by-laws did not do. The president is removed from the nominating committee; the annual election date is advanced to one day before the annual meeting to give more time to count the ballots. The executive committee is enlarged to seven members. The constitution is shorter, and many things that were in the old one are now found in the new by-laws instead.

The society admitted 145 physicians to membership in 1950, making a total membership of 1,609 as of December 1. Fourteen members died during the same period.

In the field of community service, the T.B. minifilm unit in operation at society headquarters, operating as a survey unit only, continued to serve member physicians and their patients, and in the past year did 14,482 minifilm chest x-rays. Of the 612 cases reported to the San Francisco Department of Health, 365 were cleared clinically of tuberculosis suspicion, 164 were considered healed or inactive tuberculosis, 47 were diagnosed clinically as pulmonary tuberculosis previously unsuspected, 21 with demonstrated bacilli. Thirty were recommended for hospital entry and 21 actually put in a hospital.

The publicity committee had two meetings during the year and with the cooperation of the San Francisco Hospital Conference also had a dinner meeting with representatives of all the San Francisco newspapers, news services and radio chains early in the year. This was a splendid evening where problems of mutual interest concerning the dissemination of medical news were thoroughly discussed. The speakers' bureau has continued to supply speakers not only on the subject of socialized medicine but on other aspects of medicine also. Our referral service has increased its effectiveness as the result of experience.

During the year the professional conduct committee considered approximately 67 formal complaints, i.e., those submitted in writing to the society, which is the only type considered by this committee. Of these complaints, all investigated and adjudicated by the committee, 48 were primarily concerned with fees. The committee found the chief trouble to be the usual one; neglect on the part of the physicians involved to advise the patients in advance of treatment, either medical or surgical, what the costs were to be, or the basis on which they were computed.

The *Bulletin* of the San Francisco Medical Society underwent some changes this year, all of which have

tended to streamline and make it a far more attractive and readable publication. Color was introduced for the first time and its cover was redesigned to allow for a change of photograph each month, usually of local color.

Numerous other committees were at work during the year and their accomplishments were many and varied. Much of the fine work accomplished this year was due primarily to the personnel of the committees and their indefatigable attention to their duties.

The Bureau of Medical Economics had a splendid year insofar as its membership is concerned. The San Francisco District Dental Society has worked with our society to build up the membership of the bureau, and it is hoped that 1951 will see a 100 per cent representation from both societies. The Bureau of Medical Economics has been now incorporated on its own as of San Francisco rather than as part of the former overall corporation which included Alameda and Santa Clara. This will tend for easier and more efficient operation.

As we go forth into 1951 this society is well aware that it faces even bigger problems due to a probable shortage of physicians as the armed forces fill their quotas, and because of important economic and other aspects on the home front. It is prepared to tackle and solve them to the best of the ability of its directors, officers and its membership.

ALLEN T. HINMAN, *Secretary-Treasurer*

SEVENTH DISTRICT

Alameda and Contra Costa Counties.
Donald D. Lum, Alameda, *Councilor.*

Alameda-Contra Costa Medical Association

The Alameda and Contra Costa medical societies amalgamated as of November 1, 1950, to form the Alameda-Contra Costa Medical Association. While the merger is legally and formally complete, much time and work will be behind us before we will have adapted all of the public services of the association to the differing conditions, needs and attitudes of the many communities we now serve.

Like most other societies, A.C.C.M.A.'s attention recently has been detracted from these long-range projects and focused upon the immediate urgent need for blood for the armed forces, civilian defense organization, procurement of medical officers for the military, and the other medical problems of war.

During the past year we have reaped some of the beginning rewards of a continuing, soundly based public relations program. We have achieved greater public understanding and appreciation as a result of our efforts to recognize our responsibilities, and within the limits of our best abilities to meet them—responsibilities to our patients and the public, to our members and to medicine. But there is much more to do than has been done.

PAUL MICHAEL, *Secretary-Treasurer*

EIGHTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba Counties.

Wayne E. Pollock, Sacramento, *Councilor.*

Butte-Glenn Medical Society

The Butte-Glenn Medical Society has been quite active during the past year under the guidance of Dr. Cleon Hubbard, president. Meetings have been held monthly, either business or academic. The business meetings have been quite enlightening and sometimes very warm as the local medical society has entered local politics and has taken a more active interest in the county hospital and indigent care program. There is now an active county hospital staff to assist in the guidance and care of the indigent and old age program in Butte County. There has been a committee appointed to study the possibility and advisability of working out some old age and indigent program on a C.P.S. insurance basis.

A functioning blood bank has now been established in this area with depots at the Enloe Hospital, Butte County Hospital in Oroville and the Gridley Hospital. The local blood bank is a branch unit of the Sacramento Blood Bank. Dr. Meredith Guernsey is primarily responsible for its formation. A tumor board has been discussed at length and will probably be established in due time.

J. O. CHIAPELLA, *Secretary*

Lassen-Plumas-Modoc County Medical Society

This society meets on "call" of the president. We have had several interesting meetings in 1950 in various sections of the three counties. Because of the great distances members have to travel and the fact that someone has to "cover" in each community, we never have a full attendance but usually good.

An interesting week-end meeting was held at Feather River Inn in August. Dr. Ray Kistler of San Francisco talked on surgical emergencies of the abdomen. Dr. Wayne Pollock, our Councilor, gave us a report on C.M.A. activities and their problems. At this meeting Dr. James Creever was elected president and Dr. J. D. Coulter secretary-treasurer. We enjoyed the recreational activities of Feather River Inn and hope to make this an annual week-end meeting.

Dr. MacLean, President-elect of C.M.A., visited us at a dinner meeting in Susanville on October 7, along with the Executive Secretary, Mr. John Hunton.

The Tri-County arranged meetings in the separate counties to review with various chest specialists the positive x-rays taken as a follow-up to the state tuberculosis case-finding program. These informal discussions were very instructive and enjoyable to us.

The board of directors was appointed to act as procurement and assignment for physicians in Lassen-Plumas-Modoc counties.

We deeply appreciate the efforts the speakers who have visited us have made in traveling so far to attend our meetings.

J. D. COULTER, *Secretary*

Sacramento Society for Medical Improvement

Organized in 1868, the Sacramento Society for Medical Improvement has enjoyed steady growth. The society now has 260 members, many of whom are active in local and state medical affairs. Meetings are held monthly, at which time speakers, usually from the medical schools in San Francisco, aid in keeping us informed of recent developments. An annual banquet is held March 17, and the December meeting is devoted to election of officers.

A history of the society, which includes a great many factors of interest to California medicine in general, has been written by a society member, J. Roy Jones, M.D. The history is in the form of a book entitled "Memories, Men, and Medicine" which has been published by the Sacramento society.

As another milestone in progress, the society, in 1950, inaugurated a broad and extensive public relations program, and at the end of the year publicly announced it was willing and prepared to offer to every resident of the county good medical care 24 hours a day, regardless of ability to pay.

EDMUND E. SIMPSON, *Secretary*

Shasta County Medical Society

The Shasta County Medical Society has 26 members.

Officers for the new year are: O. J. Hansen, president; L. W. Bonar, vice-president, and H. R. Eagle, secretary-treasurer.

Regular meetings of the society are held on the first Monday of each month.

H. R. EAGLE, *Secretary-Treasurer*

Yolo County Medical Society

The Yolo County Medical Society held regular monthly meetings during the year with presentations by outstanding medical men on a variety of subjects related to the practice of medicine. One meeting was devoted to a discussion of physician-patient relationships by a team of officers from the California Medical Association.

A special meeting was called by the president in August to discuss the national emergency and to elect a Procurement and Assignment Committee. Two other committees were formed this year, a Tuberculosis Committee and a Fee Schedule Committee.

New members admitted during the year were W. Pearson, John H. Saltzman, Joseph W. Cook and Harold Johnson.

CHARLES L. MCKINNEY, *Secretary*

NINTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties.
John W. Green, Vallejo, *Councilor.*

Marin County Medical Society

Marin County Medical Society has had a very worthwhile year with the normal amount of changes. The membership has now reached 78 members with several additional prospective members to be accepted in the early months of 1950. Nine monthly meetings have been held with very interesting scientific programs being given with outside speakers.

The obstetrical departments of all hospitals have been busy for the most part. The board of directors of the new hospital have made very satisfactory progress in 1950. The lower stories have already been built and the building is now ahead of schedule. When completed the county will have a 100-bed hospital of the latest construction.

CARL W. CLARK, *Secretary*

Mendocino-Lake County Medical Society

The January meeting of the Mendocino-Lake County Medical Society was held at Willits, California, on the 17th of January, 1951.

The officers for 1951 were elected as follows: Dr. Robert B. Smalley, president; Dr. Royal Scudder, secretary-treasurer; Dr. J. E. Gardner of Ukiah, delegate; Dr. Thomas Hill of Lakeport, alternate.

A committee was appointed to draw up plans for a blood bank.

A request was made to the State Health Department, the C.M.A., the California Tuberculosis and Health Association to make a study of health facilities in Mendocino County.

ROBERT B. SMALLEY, *Secretary-Treasurer*

Napa County Medical Society

The Napa County Medical Society had a successful year during 1950. Our membership decreased slightly but we have hopes the year 1951 will show us sufficient increase to allow another delegate to the California Medical Association.

Dr. John G. McGrath, a member of the staff of Napa State Hospital at Imola, gave diligent service as president and throughout the year our meetings were interesting, instructive, and profitable.

The November meeting, as usual, was held at the Veterans Home where our society has a permanent invitation to accept their hospitality during this month. This is the meeting when the officers for the ensuing year are elected and is made the chief item of business after enjoying a delicious dinner. The officers elected were:

President, Charles W. Brown; vice-president, Herbert B. Messinger; secretary, Robert Starr Northrop; delegate, George I. Dawson, and alternate, Walter H. Brignoli.

We anticipate that the coming year will show some growth in membership unless our ranks are depleted by the exigency of war.

ROBERT S. NORTHROP, *Secretary*

Siskiyou County Medical Society

The opening of a 17-bed hospital at Mount Shasta has been of great help in the southern part of Siskiyou County. Occasional meetings through the year have marked the activity of the county medical society. The efforts of Dr. H. Gordon MacLean and Mr. John Hunton in visiting this distant mountain area were much appreciated and enjoyed by the members.

WERNER F. HOYT, *Secretary*

Solano County Medical Society

The past year's activities of the Solano County Medical Society, under the guidance of Dr. Bernard V. O'Donnell as president, showed evidence of the progressive forward development which has been apparent in neighboring county medical societies.

Among the important activities accomplished during the year 1950 was the establishment of the group malpractice insurance plan, similar to that of Alameda County, to which all doctors of the Solano County Medical Society may belong. Along with this also was established a health insurance plan covering over 75 per cent of the doctors of the society.

Other important developments which have occurred were the establishment of a school health committee to work with the local school physicians in correlating health problems and the establishment of a mental health committee. Along with this, a rheumatic fever clinic in Solano County was established where patients may be referred by their private physicians if they are unable to pay for private medical care.

During the middle of the year the civilian defense program was set up under the leadership of Dr. L. S. McLean with all doctors designated into special groups or categories. Shortly following this, a military affairs committee was established for the purpose of making recommendations and working with the various draft boards of Solano County.

The Solano County Medical Society has also been interested in the formation of the Bay Area Medical Society for the purpose of correlating activities of these societies for the benefit of the individual society.

The medical society also sponsored a team in the Peanut League and is indebted to Dr. Ambrose Ryan for his untiring efforts in seeing this activity succeed.

The society was benefited at its meetings by many prominent speakers, among them Dr. Francis Chamberlain, cardiologist, who spoke on treatment of cardiac emergencies; Dr. Robert Arbuckle, radiologist, who spoke on the roentgenological diagnosis of bowel obstructions; Dr. Thomas Buckby, urologist, spoke on disease of the liver; Dr. Randall Madely spoke on ophthalmology in general practice; Dr. H. Gordon MacLean, President-elect, and Mr. John Hunton, executive secretary, spoke on problems relating to the Medical Association.

New members of the society elected during the last year were Albert Diamondstone, T. P. Sheridan, H. L. Joseph, H. William Milo, James A. Wilson, William R. Hoops, and Ernest W. Jordan.

Among the social activities enjoyed by the medical society was the party given by the woman's auxiliary at the Napa Country Club, the benefits going to the establishment of a nurses' scholarship fund. The Solano County Medical Society were the hosts of the annual four-county medical society meeting, consisting of Marin, Sonoma, Napa and Solano counties. An enjoyable evening was spent and Dr. MacLean, the President-elect of the California Medical Association, spoke. During this time he presented Dr. C. H. Bulson of Napa the 50-year pin for the continuous practice of medicine in California.

The following officers were elected in the November meeting for the year 1951: J. J. Garthe, president; R. M. Gibbons, vice-president; I. M. Shankman, secretary-treasurer; L. W. Johnson, delegate, and Felix Rossi, alternate delegate.

The last meeting of the Medical Society, held on December 19, was a purely social meeting held with the Solano County Bar Association. Guests were invited from the Mare Island Naval Hospital and the Travis Air Force Hospital. Speaker of the evening was Mr. Thomas Hadfield, an official of the American Mutual Life Insurance Company of San Francisco, who spoke on malpractice insurance.

CARL V. REICHMAN, *Retiring Secretary*

Sonoma County Medical Society

The year 1950 found the Sonoma County Medical Society, now numbering 99 members, emphasizing the importance of public relations. Initiated by Dr. Alexis Maximov, our 1949 president, this program was further and significantly developed by Dr. John Mohrman, last year's president.

Specifically, the outstanding success of the Alameda County plan prompted a careful study of their program. This culminated in September with an inspiring exposition of the philosophy and application of good public relations by Mr. Rollen Waterson. At the same meeting authority for the achievement of applicable features of this plan was voted by the society. Significant steps already taken included the obtaining of the part-time services of Mr. F. Leslie Manker, a local practicing attorney, as executive secretary, and the publishing of a printed bulletin under the editorship of Dr. William Makaroff. Another high spot was the visit of President-elect H. Gordon MacLean

and Executive Secretary John Hunton of the C.M.A., who outlined the cumulative importance of individual doctor-patient relations.

The society also took the initiative in arranging the second annual joint meeting of the local medical, dental, legal and pharmaceutical professions, at which time these subjects were discussed by Dr. Berthel Henning of San Francisco and Mr. William Winter, noted news analyst.

During the past year the Sonoma County Community Blood Bank, which has been sponsored and guided but not exclusively controlled by the medical society, expanded its activities to the processing of blood for Mendocino and Lake counties and to embarking upon a program of procuring 400 units of blood monthly for the armed forces. Dr. William Shipley, a retired society member, has been serving as medical director.

In a tribute to "old timers," Dr. Shipley and a number of other retired physicians were honored at a special meeting. It would be incomplete not to note the excellent guest speakers, Doctors Verne Inman, Ephraim Engleman, Gilbert Gordon and Roberto Escamilla, who along with several symposia employing local talent, contributed to the edification of the membership. Joint meetings with the auxiliary including a barbecue at the residence of Dr. William Makaroff completed a particularly successful year.

WILLIAM J. RUDEE, *Secretary-Treasurer*